EXHIBIT A

Graphic Packaging INTERNATIONAL

SUMMARY PLAN DESCRIPTION

HEALTHPLUS PPO MEDICAL PLANS

for Eligible Employees

SUMMARIZING MEDICAL, PRESCRIPTION DRUG, HEALTH REIMBURSEMENT ACCOUNT AND EAP BENEFITS AS OF JANUARY 1, 2021

Introduction

This booklet is a summary of the HealthPlus PPO medical plans available to eligible employees of Graphic Packaging International, LLC (GPI or the Company).

The benefits described in this booklet are effective as of January 1, 2021, and are a part of the Graphic Packaging International Health and Welfare Benefits Plan (the plan). Your eligibility can be found in your most recent *Benefits Supplement*.

This booklet, when used with the individual plan summaries referenced within, completes the summary plan description for the plan. Refer to each individual plan summary for details on plan provisions. If the plan or any plan summaries are materially modified, you will receive notification, in writing, of the plan changes and the date the changes are effective.

Every effort has been made to make this booklet easy to understand, informative and as accurate as possible. However, a full description of the plan is contained in the legal plan document, which you can review. If any conflict arises between benefits described in this booklet and any plan communications and the legal plan documents, the legal plan documents will govern.

The Company reserves the right to amend, modify, suspend or terminate the aforementioned plan (or any part of the plan) at any time and for any reason, subject (where applicable) to the collective bargaining process. The authority to amend, modify, suspend or terminate the plan lies with the Management of the Company, pursuant to the Charter of the Compensation and Management Development Committee of the Board of Directors of Graphic Packaging Holding Company. Nothing in this booklet is intended to create an employment contract between the Company and any employee.

This plan summary is also posted on the Your Benefits Resources website. If English is not your primary language, see your Human Resources representative for assistance in translation.

Note: You can view and print the *Summary of Benefits and Coverage* (as required by the Patient Protection and Affordable Care Act) for the medical option in which you are enrolled on the Your Benefits Resources website (**www.ybr.com/gpi**). *Summaries of Benefits and Coverage* for the other medical options for which you are eligible can be requested, at no cost to you, by calling the Your Benefits Resources Customer Service Center at **1-800-201-6885**.

Extended Deadlines Due to COVID-19 Pandemic

In accordance with federal guidelines, the Company is extending a number of important deadlines described in this plan summary. These extensions provide extra time for employees and their family members to:

- Provide notice of a COBRA qualifying event (or request an extension of COBRA coverage due to a second qualifying event or disability).
- Elect and pay for COBRA coverage.
- File benefit claims and appeals.

Specifically, the period beginning on March 1, 2020, and ending 60 days after the federal government announces the end of the COVID-19 national emergency period may not count for purposes of determining whether you have met these deadlines. In other words, each of these deadlines will be suspended during this period.

For more information, contact the Your Benefits Resources Customer Service Center at **1-800-201-6885**.

¿Es el español su idioma principal? Esta es una descripción de los beneficios médicos de la droga y de la prescripción a disposición a los empleados elegibles de Graphic Packaging International, LLC. Si el español es su idioma principal, consulte a su representante de Recursos Humanos para la asistencia con la traducción.

Overview

GPI offers you options that provide comprehensive coverage for a wide range of health care services including preventive care, physician services, hospitalization and prescription drugs. To help with your out-of-pocket expenses (deductible, coinsurance and copays), you can use money you earn in your Company-funded health reimbursement account.

In addition to these plans, the Company offers you the choice of a "health savings account" medical option. Refer to the HealthPlus HSA medical plan summary for details on this plan.

It is up to you to pick the option that provides the level of financial protection that you and your family will need in the event of illness or injury.

Your Eligibility

This summary plan description describes the specific benefits of your Company HealthPlus PPO medical plans. Your most recent *Benefits Supplement,* which should be reviewed along with this summary, provides details on:

- Other Company-sponsored medical options that may be available to you.
- Your eligibility.
- Your family member's eligibility.
- How to enroll for coverage.
- When your coverage begins.
- How to change your coverage — following a qualifying status change event, special enrollment or during annual enrollment.
- When your coverage ends.
- Your rights for continuing your coverage under COBRA.
- Plan administration, including your rights under ERISA.

Take time to read both booklets carefully so you are familiar with the enrollment requirements and benefit provisions, limitations and exclusions of the HealthPlus PPO medical options.

Key Features of the HealthPlus PPO Medical Plans

Here is a summary of the key features of these plans:

- You can choose from one of four HealthPlus PPO medical plans or the HealthPlus HSA medical plan. Or, you can elect "no coverage."
- You may enroll yourself and your eligible family members. Eligible family members include your legal spouse and children. Documentation supporting the relationship of these family members is required when coverage is initially requested. If documentation is not received timely, your family members will not be eligible or enrolled. See your most recent *Benefits Supplement* for details.

- All your HealthPlus PPO medical options include:
  - A calendar year deductible and out-of-pocket maximum that limit the amount you spend on most covered medical services.
  - A health reimbursement account (HRA) funded by the Company after your complete certain Healthy Rewards activities through GPI FIT. Your HRA can be used to help pay your deductible, copays and out-of-pocket expenses under GPI medical, dental and vision plans.
  - Coverage for a broad range of medical services and supplies.
  - Freedom to select your own health care provider — without referral.
  - Access to a network of physicians and medical facilities at reduced costs. You decide whether you want to see a provider in the Anthem Blue Cross Blue Shield (Anthem BCBS) network or an out-of-network provider — each time you need medical care. When you use in-network providers, you pay less for your care. In addition, network providers will file claims for you.
  - Coverage for prescription drugs filled through a local CVS Caremark network pharmacy, the CVS Caremark Mail Service Pharmacy or the CVS Specialty Pharmacy. You must follow plan rules for filling ongoing long-term (maintenance) and specialty prescriptions — or your cost for the medication may not be covered. Prescriptions filled outside the CVS Caremark network are not covered.
  - 100% coverage for preventive care with no deductible — when you use a network provider. This includes age-based routine exams, annual screenings, immunizations and certain preventive medications.
  - Requirements to obtain prior authorization for inpatient stays, surgery, many outpatient procedures and supplies, transplants (including travel and lodging) and certain prescription drugs. If you do not get prior authorization, the services may not be covered by the plan.
  - No lifetime maximum.
- Regardless of whether you enroll in a Company medical plan, the following benefits are available at no cost to you:
  - Access to an employee assistance plan (EAP), including TeleEAP health coaching, through Magellan Healthcare — for you and each of your family members.
  - Help quitting tobacco with the Clickotine tobacco cessation program — for you and your spouse. The program includes a personalized quit plan, tools, coaching and over-the-counter nicotine replacement medications. In addition, if you are enrolled in a HealthPlus medical option, certain medications in connection with withdrawal from nicotine may be covered.
- The cost for medical coverage is shared between you and the Company. Your contributions for medical coverage (if elected) are withheld from your paycheck on a pre-tax basis. The exact amount of your paycheck deduction will depend on which option you choose and the eligible family members you elect to cover. If you elect "no coverage" there is no cost to you.
- Plan claims are administered by:
  - Medical: Anthem BCBS.
  - Prescription drugs: CVS Caremark.
  - HRA: HealthEquity.
  - Activities to earn Company contributions to your HRA: GPI FIT (**www.gpifit.com**).

Additional Resources

In addition to this booklet and your most recent *Benefits Supplement*, you have other resources for information.

Note: If English is not your primary language, you can request a translator.

Who	What You Can Do	Contact Information
Your Benefits Resources *General benefits and enrollment information*	• Enroll when first eligible • Review high level summaries of your health care options, along with your costs for each option • Access tools to compare options and decide which plans are right for you and your family • Change your elections following a qualifying status change event, special enrollment period or during annual enrollment • Confirm your enrollment, including who is enrolled and your per pay period cost for coverage • Review and print plan summaries and enrollment guides	**1-800-201-6885** **www.ybr.com/gpi** Representatives are available Monday through Friday, 8 a.m. to 9 p.m. Eastern Time, excluding major holidays *Si su idioma principal es el español, llame a* **1-800-201-6885** *y diga "representative." Una vez conectado, solicite un traductor español. El traductor, junto con el representante, pueden responder a sus preguntas y ayudarle a inscribirse en sus beneficios. El sitio web también está disponible en español.*
Dependent Verification Center *Family member eligibility and verification information*	• Find a listing of acceptable documentation to support eligibility for family members you want to enroll • Submit documentation to verify eligibility for family members • Confirm the status of review for documentation you have submitted • Get answers to your questions	**1-800-201-6885** **www.ybr.com/gpi** Click on the "Dependent Verification" tile or ask to speak with a Dependent Verification Center representative Representatives are available Monday through Friday, 8 a.m. to 11 p.m. Eastern Time, excluding major holidays
Anthem Blue Cross Blue Shield (Anthem BCBS) *Medical benefits: what's covered, prior authorization review, claims, ID cards*	• Locate network providers • Learn what's covered under the medical plan in which you are enrolled, including the age and frequency guidelines for preventive services • Confirm what services require prior authorization and request prior authorization review • Check the status of claims • File an out-of-network claim • Research specific health and wellness information from Anthem BCBS's online health library • Print a temporary ID card and request new or additional ID cards	**1-855-272-0696** **www.anthem.com** Representatives are available Monday through Friday, 8 a.m. to 8 p.m. Eastern Time, excluding major holidays
CVS Caremark *Prescription drug benefits: what's covered, prior authorization review, claims, ID cards*	• Locate CVS Caremark network pharmacies near you (including local CVS Pharmacy stores) • Learn about what medications are covered under the medical plan in which you are enrolled, including preventive medicines • Confirm which medications have generic alternatives, what drugs are on the CVS Caremark Performance Drug List and what medications are on the "specialty" medication list • Find out what medications require prior authorization and request prior authorization review • Start or refill mail service or specialty prescriptions • Research the latest information about prescription drugs and health conditions • Print a temporary ID card and request new or additional ID cards	**1-800-774-5780** **www.caremark.com** FastStart for Mail Order: **1-866-776-5677** CVS Specialty Pharmacy: **1-800-237-2767** **www.cvsspecialty.com** Representatives are available 24 hours a day/7 days a week

Who	What You Can Do	Contact Information
LiveHealth Online *Virtual doctor visits for participants enrolled in a HealthPlus medical plan*	• Talk with an in-network doctor on your computer or smart device • Get immediate care for many common conditions, such as flu, allergies and cold/fever • Obtain a prescription for medications to treat your condition, when needed and allowed by law	**www.livehealthonline.com** Doctors are available 24 hours a day/ 7 days a week
Teladoc Medical Experts *Second opinions for participants enrolled in a Company medical plan*	• Get free, confidential support for a wide range of medical conditions ranging from back pain and sports injuries to a cancer diagnosis • Available to you and your family members enrolled in a Company medical plan	**1-800-TELADOC (835-2362)** **www.teladoc.com/medicalexperts** Representatives are available Monday through Friday, 8 a.m. to 9 p.m. Eastern time, excluding major holidays Critical Case Support available 24 hours a day/ 7 days a week
Solera Diabetes Prevention Program	• A no-cost 16-week program to help you lose weight, adopt healthy habits and reduce the risk of developing diabetes • Includes online or in-person options	**Text "gpi" to 81053** **www.solera4me.com/gpi**
GPI FIT *Resources for wellbeing: Health Assessment, health coaching, activities for earning Healthy Rewards (for participants enrolled in a HealthPlus medical plan); enrollment in a GPI medical plan not required*	• Find personalized resources to help you plan and achieve your health goals — all in a private, secure environment • Earn Company contributions to your HRA based on your completed activities • Available to you and your enrolled spouse	**1-833-862-9191** **www.gpifit.com** Representatives are available Monday through Thursday, 9 a.m. to 8 p.m. and Friday 9 a.m. to 7 p.m., excluding major holidays All times are Eastern Time
HealthEquity *HRA benefits: eligible expenses, account balance, claims, direct deposit, debit card*	• Learn about eligible expenses • Review your claims • Confirm contributions to your account • Check your account balance • Submit or approve a claim for reimbursement • Set up direct deposit for claim payments • Request new or additional debit cards	**1-866-346-5800** **www.myhealthequity.com** Representatives are available 24 hours a day/7 days a week
Magellan Healthcare *EAP counseling and TeleEAP health coaching; enrollment in a GPI medical plan not required*	• Request confidential counseling with an EAP mental health professional • Get help from a health coach on a wide-range of issues • Access the online Learning Center for health information and tools	**1-800-327-9781** **www.magellanascend.com** Counselors are available 24 hours a day/7 days a week
Clickotine *Help quitting tobacco dependency*	• Download the mobile app to participate in a no-cost tobacco cessation program • Get up to 26 weeks of over-the-counter nicotine replacement medications (such as patches or gum) • Available to you and your spouse — even if you are not enrolled in a Company medical plan	**1-800-327-9781** **www.magellanascend.com** Help accessing the app is available 24 hours a day/7 days a week
Advocacy Services *Benefits, claim and billing support*	• Contact a Health Pro consultant to get help with your benefits and care, including transfer of medical records and scheduling appointments • Resolve billing and benefit claim disputes	**1-800-513-1667** Representatives are available 24 hours a day/7 days a week

Member Identification Cards

If you elect a Company-sponsored medical plan, you will receive plan identification (ID) cards from Anthem BCBS and CVS Caremark. These cards contain important information for you and your health care providers. You should present your ID card to your provider each time you receive care. By doing so, your providers and pharmacies will have the most current information, minimizing errors and delays in the filing and processing of your claims.

If you lose your ID card, or need another one, you can request a replacement by calling Anthem BCBS or CVS Caremark or visiting each plan's website.

You may also receive a debit card from HealthEquity. You can use this card to cover your out-of-pocket health care costs with money from your HRA.

Table of Contents

General Provisions of the Plan

It is your responsibility to read this booklet and any related updates completely and comply with the requirements of the plan. The plan's provisions determine what services and supplies are eligible for coverage. The fact that your provider has performed or prescribed a procedure or treatment does not mean that it is a covered service or supply under the plan. The ultimate decision as to what medical care you and your enrolled family members actually receive, and where you receive it, must be made by you and your health care provider. However, only services approved by the plan will be covered.

Plan Benefits

The payment of any plan benefit depends on the type of service or supply provided and whether the service or supply is:

- Delivered by an eligible provider.
- Provided within the network or out of the network.
- Medically necessary.
- Within the maximum allowed amount.
- A covered expense under the plan.
- Authorized, in advance of your treatment for inpatient stays, surgery, many outpatient procedures and supplies, transplants (including travel and lodging) and certain prescription drugs requiring prior authorization.

IMPORTANT! The HealthPlus PPO plan option in which you are enrolled, and the family members you choose to enroll, will determine how much you pay and how much this plan pays for covered expenses.

Choosing a Health Care Provider

Each time you need medical care, you can decide whether you want to see an Anthem BCBS provider in your network or a provider outside the network.

Regardless of who delivers your care, inpatient admissions and certain services and supplies must be authorized by Anthem BCBS in advance of your treatment — or it may not be covered by the plan. See "Prior Authorization" for more information.

ANTHEM BCBS NETWORK

IMPORTANT! Network providers change periodically. It is your responsibility to verify that your provider is in your Anthem BCBS network — before you receive your care.

The Anthem BCBS network includes hospitals, doctors, physical therapists, mental health providers, home health care specialists and other health care professionals throughout the United States. Network providers have contractually agreed to a fee schedule with Anthem BCBS that is equal to or less than the reasonable and customary allowance — reducing costs to both you and the Company.

When you use a network provider, you:

- Are charged less for the services you receive.
- Pay less for your share of the costs.
- Do not have to file your claim (the provider will file your claims directly for you).
- Are not billed for charges over the maximum allowed amount.

To find an Anthem BCBS network provider, call Anthem BCBS at **1-855-272-0696** or visit **www.anthem.com** and select "Find a Doctor/Find Care."

Your network depends on where you live and receive your care:

- **If you live in Georgia; New Hampshire; the St. Louis, Missouri area; Tennessee; or Wisconsin**, your network is the Select Network for care received in your area and the National BlueCard PPO network for care received outside your area.

  To find your Select Network on the Anthem website as a guest, refer to the list below. If you log in with your Anthem BCBS user ID and password, your network will automatically be selected.

If You Live In…	Your Select Network Is…
Georgia	GVA Select Network
New Hampshire	GVH Select Network
St. Louis, Missouri Area	GVG Select Network
Tennessee	GXT Select Network
Wisconsin	GVR Select Network

- **If you live outside one of these areas**, your network is the National BlueCard PPO network.

OUT-OF-NETWORK PROVIDERS

IMPORTANT! Some services and supplies are only covered when delivered by a network provider. See "Schedule of Benefits" and "Covered Services and Supplies" for more information.

The plan covers many medical services delivered by a provider who is not in the Anthem BCBS network.

If you receive care from an out-of-network provider that is covered under the plan:

- You are responsible for filing claims.
- You may have a higher cost sharing through the plan's deductible, coinsurance and out-of-pocket maximum.
- Providers can bill you for the difference between their bill and the plan's maximum allowed amount — in addition to any deductible or coinsurance required by the plan.
- Generally, benefits are paid directly to you and you are responsible for paying the provider.

In emergency situations, contact Anthem BCBS within two business days after you receive care and your charges may be considered at the in-network level.

Prescription Drug Network

IMPORTANT! The plan only covers prescriptions filled within the CVS Caremark network. This includes network retail pharmacies, your local CVS Pharmacy store, the CVS Caremark Mail Service Pharmacy and the CVS Specialty Pharmacy.

Prescriptions filled at pharmacies that are not in the CVS Caremark network are not covered.

CVS Caremark provides the prescription drug network. The plan covers outpatient prescription drugs purchased through a pharmacy that is part of the CVS Caremark network — including designated retail pharmacies, your local CVS Pharmacy store, the CVS Caremark Mail Service Pharmacy and the CVS Specialty Pharmacy[1].

To find a retail CVS Caremark network pharmacy, log on to **www.caremark.com** (registration required), or call CVS Caremark Customer Care at **1-800-774-5780**.

1 *Prescription drugs administered while confined as an inpatient, in your doctor's office, as part of a home health care treatment, or during chemotherapy generally are covered under the medical provisions of this plan.*

Medically Necessary

Benefits are payable only for services or supplies that are determined by the plan's claims administrators to be medically necessary. Even though a doctor performs or prescribes a procedure or level of care, or that it may be the only treatment for a particular health condition, it may not be medically necessary or a covered expense under the plan.

Anthem BCBS determines whether a service or supply is medically necessary. CVS Caremark determines whether an outpatient prescription drug is medically necessary.

Care is considered medically necessary if it meets all of the following conditions:

- It is appropriate given the symptoms and is consistent with the diagnosis.
- It is related to the diagnosis, evaluation or treatment of your illness or injury (other than covered preventive care).
- It is rendered in accordance with generally accepted medical practice and professionally recognized standards.
- It is known to be effective, as proven by scientific evidence, in materially improving health outcomes.
- It is cost-effective compared to alternative interventions, including no intervention.
- It is not regarded generally as experimental, educational, investigative, unproved or obsolete.
- It is provided in the most appropriate setting, level of service or supply that can be safely provided for your medical condition, consistent with recognized professional standards of care (which, in the case of hospitalization, also means that safe and adequate care could not be obtained in a less comprehensive setting).
- It is not provided primarily for the convenience and/or comfort of you, your family, your doctor or another provider of services.
- It is specifically allowed by the licensing statutes that apply to the provider who renders the service.
- It is not otherwise excluded under this plan.

In reviewing whether a **medical service or supply** is medically necessary, Anthem BCBS will consider a number of factors, including:

- Your health status.
- Peer information published in medical literature.
- Reports and guidelines (that include supporting scientific data) published by nationally recognized health care organizations.
- Professional standards for safety and effectiveness which are generally recognized in the United States for the diagnosis, care or treatment of an illness or injury.
- The opinions of health care professionals in the health care specialty involved.
- The opinion of your treating doctor.
- Any other information that may be important to your situation.

In reviewing whether a **prescription drug** is medically necessary, CVS Caremark will review your health status and diagnosis to determine whether the medication:

- Is approved by the FDA for your particular condition.
- Meets CVS Caremark's criteria for clinical efficacy (with respect to both the type and brand of medication).

Maximum Allowed Amount

Benefits under the plan are based on the plan's "maximum allowed amount" for covered services and supplies.

MEDICAL SERVICES AND SUPPLIES

Anthem BCBS determines whether a medical service or supply is within the maximum allowed amount.

- **For providers who are in-network**, the maximum allowed amount is based on the contractual agreement between Anthem BCBS and the provider.
- **For providers who are out-of-network**, the maximum allowed amount is based on the lesser of:
  - The provider's normal charge for a similar service or supply.
  - The reasonable and customary allowance for the service. For a charge to be considered reasonable and customary, the charge may not exceed the usual charge billed by other health care providers in the geographic area for similar services and supplies, as determined by Anthem BCBS. Consideration is given for unusual circumstances or complications that require additional time, skills or experience.

  Anthem BCBS compiles the information and makes this determination.

You are responsible for any charges that are more than the maximum allowed amount. These additional amounts do not count toward your deductible or out-of-pocket maximum but may be eligible for reimbursement from your HRA.

PRESCRIPTION DRUGS

CVS Caremark determines whether an outpatient prescription drug charge is within the maximum allowed amount. The maximum amount is based on the contractual agreement between CVS Caremark and the network pharmacy.

Covered Expenses

Covered expenses are the charges incurred for services and supplies that are:

- Medically necessary for the treatment of the illness or injury or, with respect to preventive care, required to be covered under federal law.
- Recommended by a doctor or eligible health care provider.
- Within the maximum allowed amount.
- Authorized, in advance of your treatment, for inpatient stays, surgery, many outpatient procedures and supplies, transplants (including travel and lodging) and certain prescription drugs requiring prior authorization.
- Specifically listed as a covered expense.

In some cases, your provider may recommend or provide written authorization for services that are specifically excluded by this plan. When these services are referred or recommended, a written authorization from your provider does not make it a covered expense under this plan.

Eligible Health Care Providers

Eligible health care providers include hospitals, health care facilities, individual health care practitioners, pharmacies and other ancillary health care professionals, provided they hold a license under the applicable state licensing law and are practicing within the scope of their license. Individual practitioners include the following:

- Medical doctor (M.D.).
- Doctor of osteopathic medicine (D.O.).
- Nurse.
- Nurse Practitioner.
- Nurse Midwife.
- Certified Registered Nurse Anesthetist.
- Physician's Assistant.
- Social Worker (who holds a Master's level degree and is working under the supervision of a clinical psychologist or medical doctor).
- Clinical psychologist.
- Doctor of chiropractic (D.C.).
- Physical, speech, occupational, cardiac and pulmonary therapists.

The health care provider cannot be an immediate relative (spouse or domestic partner (whether or not legally recognized), parent, child, sibling, in-law, grandparent and grandchild — by blood, marriage or adoption) or a member of your household (anyone living in your home, as well as your children who are regularly attending school on a full-time basis).

Prior Authorization

IMPORTANT! If the prior authorization review finds that the services or supplies are not medically necessary, the charges will not be covered by the plan.

Some services and supplies must be authorized by Anthem BCBS or CVS Caremark — before you receive care. Prior authorization evaluates:

- The need for the services.
- Whether the services will be covered by the plan.
- How long the services will be covered, such as a hospital stay.

In most cases, your provider will request prior authorization for you. **Ultimately it is your responsibility to be sure that prior authorization is received before the services or supplies are delivered.**

Contacting Anthem BCBS or CVS Caremark in advance does not guarantee payment. For example, if you are no longer a participant in the plan on the date you receive treatment, your charges will not be covered — even if you received prior authorization.

PRIOR AUTHORIZATION OF MEDICAL SERVICES AND SUPPLIES

IMPORTANT! The services and supplies that require prior authorization change from time to time. Be sure to contact Anthem BCBS at least 10 business days before you receive treatment to confirm whether prior authorization is required.

To request prior authorization, call Anthem BCBS Customer Service at **1-855-272-0696** within 10 business days before your treatment is scheduled.

Most network providers will contact Anthem BCBS to get prior authorization for you. To confirm whether prior authorization is required, talk with your provider (in-network or out-of-network) about contacting Anthem BCBS to get the appropriate authorization for those services and/or supplies — before you receive care.

Categories of services that require prior authorization include, but are not limited to:

- Inpatient stays, including hospitals, rehabilitation facilities and skilled nursing facilities. If your situation is life-threatening, you should seek care from the nearest emergency room. If you are admitted, you, a family member, or your doctor should call Anthem BCBS within two business days after seeking emergency care in order for your benefits to be considered at the in-network level.
- Inpatient stays for childbirth that exceed 48 hours for a normal delivery or 96 hours for a cesarean delivery[1].
- Newborn stays after the mother is discharged.
- Alternatives to inpatient stays, including:
  - Residential treatment programs.
  - Intensive outpatient therapy.
  - Partial hospitalization programs.
- Advanced diagnostic testing.
- Radiation therapy and radiology services.
- Applied behavioral analysis or applied behavioral therapy.
- Durable medical equipment and prosthetics.
- Many surgical procedures, including but not limited to surgery for morbid obesity and gender affirming surgery.
- Travel and lodging as allowed under the plan.
- Certain outpatient procedures.
- Out-of-network referrals, when consideration of in-network benefit levels are being requested.

For a full listing of services that require prior authorization, contact Anthem BCBS.

1 *The plan automatically covers maternity stays for up to 48 hours following a vaginal delivery or 96 hours following a cesarean section delivery. If your hospital stay must be extended due to complications, you must contact Anthem BCBS immediately. If you do not, your extended stay may not be covered.*

PRIOR AUTHORIZATION OF PRESCRIPTION DRUGS

IMPORTANT! The listing of medications subject to prior authorization changes from time to time. Be sure to check with CVS Caremark before you fill your prescription.

To request prior authorization, have your doctor call CVS Caremark at **1-800-294-5979** — before you fill your prescription.

Most medications do not require prior authorization. However, the following prescriptions require prior authorization to confirm the need for the medication and the quantity that has been prescribed:

- Certain specialty medications found on the CVS Specialty Pharmacy Drug Listing (available at **www.cvscaremarkspecialtyrx.com**).
- Erectile dysfunction medications, for an unrelated organic illness, subject to dispensing limitations.
- Antifungal medications.
- Topical acne medication for anyone over the age of 34.
- Gonadotropin-releasing hormone agonists (Lupron products, Supprelin® LA, Zoladex®).
- Additional quantities of medications used to treat acute migraine headaches after the initial quantity is reached.

PRIOR AUTHORIZATION FOR ORGAN TRANSPLANTS

All transplants must be authorized, in advance through Anthem BCBS in advance of the surgery. To request prior authorization, you or your doctor should call Anthem BCBS Customer Service at **1-855-272-0696**.

Prior authorization is required for:

- All inpatient admissions for solid organ and bone marrow/stem cell transplants, including kidney only transplants.
- All outpatient procedures considered to be transplant or transplant-related, including but not limited to:
  - Donor leukocyte infusion.
  - Intrathecal treatment of Spinal Muscular Atrophy.
  - Stem cell/bone marrow transplant (with or without myeloablative therapy).
  - (CAR) T-cell immunotherapy treatment, including but not limited to axicabtagene ciloleucel (Yescarta™); tisagenlecleucel (Kymriah™); and brexucabtagene autoleucel (Tecartus).
  - Gene therapy treatment and replacement.

Under certain circumstances, additional benefits may be payable for travel and lodging, when authorized, in advance, through Anthem BCBS. See "Organ and Bone Marrow/Stem Cell Transplants" for more information.

DECISION ON PRIOR AUTHORIZATION REVIEWS

You will be notified of the decision on prior authorization reviews within the following timeframes:

- **If your condition is urgent**, you will be notified verbally of the decision as soon as possible, but no later than 72 hours after the request is received. Any verbal decisions will be followed by a written notification within three calendar days. If additional information is needed to make a decision, you will be notified within 24 hours. Anthem BCBS or CVS Caremark, as applicable, will notify you of its final decision within 48 hours after all the information has been received.

  For purposes of this plan, "urgent" means that a quick decision is needed because any delay could jeopardize your life or health, your ability to regain maximum function or, in the opinion of a doctor with knowledge of your medical condition, subject you to severe pain that cannot be managed without the care or treatment.

- **If your condition is not urgent**, you will be notified of the plan's decision within 15 calendar days after receiving your request. This 15-day period may be extended for an additional 15 days if special circumstances apply. If an additional 15 days is needed, you will be notified.

  If additional information is needed to make a decision, you will be notified and have up to 45 days to provide the information.

- **If you received prior authorization for a defined period of time or a specific number of treatments**, and you requested an extension of the coverage, you will be notified of the decision on your request based on whether your condition is urgent (as defined above) or non-urgent.

If your prior authorization request is denied, the notice will provide information on how to appeal the decision. See "Appealing Denied Claims" for more information.

Additional Assistance

IMPORTANT! If English is not your primary language, you can request a translator for your preferred language.

The plan offers additional programs — at no cost to you — to help manage your health.

FUTURE MOMS MATERNITY PROGRAM

Future Moms assists women during pregnancy, regardless of whether the pregnancy is routine or high risk.

Call **1-800-828-5891** to speak with a registered nurse who can:

- Educate you on what you should and should not do during your pregnancy to optimize your health — and the health of your baby.
- Answer questions about your pregnancy and what to expect as your child develops.
- Help you understand and follow your doctor's plan of care.

24/7 NURSELINE

The Anthem BCBS 24/7 NurseLine provides around-the-clock registered nurses who can help you understand a medical problem, evaluate self-care possibilities and research treatment options. The program also gives you access to a library of recorded information on more than 300 topics — in both English and Spanish.

For more information, call **1-800-700-9184**.

COMPLEXCARE

ComplexCare provides assistance for individuals with multiple health issues or a condition that increases the risk of frequent and high levels of medical care, such as cancer or chronic kidney disease.

Call **1-855-272-0696** to get connected with a nurse who will work with you and your doctor to create an individualized plan that includes:

- Personalized one-on-one attention, goal planning and health/lifestyle coaching.
- Strategies to help promote self-management skills and medication adherence.
- Resources to answer health-related questions for specific treatments.
- Access to other essential medical management programs.
- Coordination of care between your providers and other services you may need.
- Information to help you make informed decisions about your health care.

If you are identified as a candidate for this program through your claim history, a ComplexCare nurse may reach out to you directly.

TELADOC MEDICAL EXPERTS

Teladoc medical experts are available if you have questions about a proposed treatment or want a second opinion.

Call **1-800-TELADOC (835-2362)** if you or your enrolled family member:

- Are unsure about a diagnosis or need help choosing treatment.
- Have medical questions or concerns and want a leading expert's advice.
- Need help finding a local expert who specializes in treating your condition.

Representatives are available Monday through Friday, from 8 a.m. to 9 p.m. Eastern time, excluding major holidays. If your case is urgent, critical case support is available 24 hours a day, 7 days a week.

SOLERA DIABETES PREVENTION PROGRAM

Learn more about your risk for diabetes and ways to help manage your health.

Solera Diabetes Prevention Program offers a 16-week program to help you lose weight, adopt healthy habits and reduce your risk of developing diabetes. The program is available online and in-person.

For more information and to see if you qualify, **text "GPI" to 81053** or visit **www.solera4me.com/gpi**.

Care Outside the United States

IMPORTANT! Contact Anthem BCBS Customer Service before you leave the country to get more information about your level of protection and what to do if you need treatment while traveling.

While medical care may be covered, prescription medications filled outside the United States generally are not covered — unless they are provided during an inpatient confinement that is covered under the plan.

Generally, emergency care received outside the United States is covered, subject to all provisions of this plan.

Note: Prescriptions filled outside of the United States are generally not covered by the plan.

MEDICAL EMERGENCIES

If you or a family member has a medical emergency while traveling outside the United States, go to the nearest health care facility and call Anthem BCBS Customer Service as soon as possible. If you are not able to make the call, a family member, friend or health care professional can make the call for you.

NON-EMERGENCY TREATMENT

If you have scheduled routine or non-emergency care outside the United States, you must contact Anthem BCBS Customer Service — in advance of your treatment — to confirm whether the services are covered expenses. If you do not make the call before care is received, the services may not be covered by the plan. Any care determined to be covered under the plan will be covered at the out-of-network levels.

WHAT TO DO AFTER YOU RECEIVE CARE

If you receive care, take the following steps:

- Pay the provider. Be sure to get a receipt to submit with your claim.
- Get documentation for the services you received. Documentation, in English, should include:
  - Your name.
  - The patient's name.
  - The date(s) of service.
  - The amount charged for each service.
  - The diagnosis.
  - A medical narrative summarizing the type(s) of services delivered.
  - The provider's name, address and phone number.
- Complete and return a claim form, along with your receipts and documentation, to the address on the form. Anthem BCBS Customer Service can provide you with the appropriate claim form based on your situation. If your claim is approved, you will be reimbursed the maximum allowed amount for any medically necessary covered expenses, based on the benefit provisions of the plan.

How the Plan Works

The HealthPlus PPO medical plans:

- **Cover the same services and supplies.** What differs is the amount of cost sharing through deductibles, coinsurance and payroll contributions. Your share of the cost depends on the option you choose, which family members you have enrolled, the service or supply you receive and whether your care is delivered by an in-network provider or out-of-network provider.
- **Include a health reimbursement account (HRA).** Money in your HRA can be used to help cover your eligible out-of-pocket expenses (deductible, coinsurance and copays) from your GPI health care plans during the year.

You choose the option that works best for you and your family.

IMPORTANT! Covered expenses for **preventive care (including preventive medications) and well child care** (including routine immunizations, other than for travel) that meet Anthem BCBS Preventive Medicine Guidelines for service, age and frequency are covered at 100% and are not subject to the deductible, coinsurance or out-of-pocket limit — when services are delivered by an Anthem BCBS network provider. Refer to "Preventive Care for Adults," "Well Child Care," and "Prescription Drug Coverage" for more information.

Deductible

The deductible is the amount you pay each calendar year (January 1 through December 31) before the plan begins to pay any portion of the cost of covered expenses for covered services. Each January 1, your deductible starts over.

A separate deductible is paid for each eligible, enrolled family member, with a maximum of two deductibles per family.

The amount of the deductible is determined by the HealthPlus PPO medical plan in which you are enrolled and whether you use an Anthem BCBS provider in your network or an out-of-network provider.

The deductibles by plan are:

Deductible per Calendar Year

Amount You Pay for Covered Expenses Before the Plan Pays

Your Plan Enrollment	If You Use a Network Provider	If You Use an Out-of-Network Provider[1]
HealthPlus Economy PPO	$5,000 individual $10,000 family	$8,000 individual $16,000 family
HealthPlus Basic PPO	$2,200 individual $4,400 family	$4,400 individual $8,800 family
HealthPlus Standard PPO	$1,600 individual $3,200 family	$3,200 individual $6,400 family
HealthPlus Premium PPO	$1,200 individual $2,400 family	$2,400 individual $4,800 family

If you have family members enrolled, the family deductible can be met by expenses from any combination of two or more covered family members. When one individual satisfies the individual deductible, no additional deductible is required for that individual for the remainder of the calendar year. Once the family deductible is met, no additional deductible is required for any covered family members for the remainder of the calendar year.

1 *The plan does not cover certain services delivered by out-of-network providers.*

Amounts applied toward the deductible for Anthem BCBS network providers also apply toward the deductible for out-of-network providers, and vice versa.

The deductible does not apply to:

- Preventive care and well child care that (1) are delivered by an Anthem BCBS network provider, and (2) meet the Anthem BCBS Preventive Medicine Guidelines for service, frequency and age (refer to "Preventive Care for Adults" and "Well Child Care" for more information).
- Outpatient prescription drugs (a separate copay or coinsurance may apply).
- Tubal ligation when the surgery is performed by an Anthem BCBS network provider.
- Expenses not covered by the plan.

Coinsurance

Once you have met your deductible, you and the plan share in the costs of your covered expenses. This is called coinsurance.

The amount of the coinsurance is determined by the HealthPlus PPO medical plan in which you are enrolled and whether you use an Anthem BCBS provider in your network or an out-of-network provider, as shown below:

Coinsurance

Amount You Pay for Covered Expenses After Deductible; Plan Reimburses Remaining Amount for Covered Expenses

Your Plan Enrollment	If You Use a Network Provider	If You Use an Out-of-Network Provider[1]
HealthPlus Economy PPO	50%	70%
HealthPlus Basic PPO	30%	50%
HealthPlus Standard PPO	20%	40%
HealthPlus Premium PPO	10%	30%

Coinsurance applies to all expenses except:

- Preventive care and well child that (1) are delivered by an Anthem BCBS network provider, and (2) meet the Anthem BCBS Preventive Medicine Guidelines for service, frequency and age (refer to "Preventive Care for Adults" and "Well Child Care" for more information).
- Outpatient prescription drugs (a separate copay or coinsurance level may apply).
- Tubal ligation when the surgery is performed by an Anthem BCBS network provider.
- Expenses not covered by the plan.

Refer to the "Schedule of Benefits" for more information.

1 The plan does not cover certain services delivered by out-of-network providers.

Medical Out-of-Pocket Limit

The maximum amount that you have to pay in out-of-pocket expenses for covered expenses in any one calendar year is called your medical out-of-pocket limit. Your medical out-of-pocket limit includes your deductible and share of coinsurance for most covered expenses that are reimbursed by the plan.

The medical out-of-pocket limit applies to each family member, with a maximum family medical out-of-pocket limit equal to two times the individual out-of-pocket limit. The family medical out-of-pocket limit can be met by expenses from any combination of two or more covered family members.

The medical out-of-pocket limit is determined by the HealthPlus PPO medical plan in which you are enrolled and whether you use an Anthem BCBS provider in your network or an out-of-network provider, as shown below:

Medical Out-of-Pocket Limit

Maximum Amount You Pay Per Calendar Year for Covered Expenses

Your Plan Enrollment	If You Use a Network Provider	If You Use an Out-of-Network Provider[1]
HealthPlus Economy PPO	$6,500 individual $13,000 family	$13,000 individual $26,000 family
HealthPlus Basic PPO	$5,200 individual $10,400 family	$10,400 individual $20,800 family
HealthPlus Standard PPO	$4,600 individual $9,200 family	$9,200 individual $18,400 family
HealthPlus Premium PPO	$4,200 individual $8,400 family	$8,400 individual $16,800 family

1 *The plan does not cover certain services delivered by out-of-network providers.*

Amounts applied toward the out-of-pocket limit for Anthem BCBS network providers also apply toward the out-of-pocket limit for out-of-network providers, and vice versa.

Once you reach the out-of-pocket limit, the plan reimburses 100% of covered expenses for the remainder of that calendar year. Each January 1, your out-of-pocket limit starts over.

The following expenses do not apply toward the medical out-of-pocket limit:

- Preventive care and well child care that (1) are delivered by an Anthem BCBS network provider, and (2) meet the Anthem BCBS Preventive Medicine Guidelines for service, frequency and age (refer to "Preventive Care for Adults" and "Well Child Care" for more information).
- Outpatient prescription drugs (a separate out-of-pocket limit applies).
- Services not covered by the plan.

Prescription Drug Benefits

The plan includes coverage for outpatient prescription drugs purchased through a pharmacy that is part of the CVS Caremark network — including retail pharmacies, your local CVS Pharmacy store, the CVS Caremark Mail Service Pharmacy and the CVS Specialty Pharmacy[2].

Prescriptions filled at retail pharmacies that are not in the CVS Caremark network are not covered.

2 *Prescription drugs administered while confined as an inpatient, in your doctor's office, as part of a home health care treatment, or during chemotherapy generally are covered under the medical provisions of this plan.*

PRESCRIPTION DRUG COPAYS AND COINSURANCE

You and the plan share in the cost of covered expenses for most prescription drugs each calendar year until you meet the prescription drug out-of-pocket maximum. The amount of your prescription drug copay is determined by:

- The type of medication.
- Whether you receive a generic substitute, when available.
- Whether you fill your prescription with a "preferred brand-name" drug from the CVS Caremark Performance Drug List, when available, or a "non-preferred brand-name" drug.
- Where your prescription is filled.
- Whether you have received prior authorization, when required.

Prescription Drug Copays and Coinsurance[3]

Amount You Pay Per Prescription for Covered Medications

Drug Class	Retail Network Pharmacy (up to 30-day supply)	Mail Service or Local CVS Pharmacy Store (up to 90-day supply)
Generic[4]	$7.50 copay/Rx	$18.75 copay/Rx
Preferred Brand-name	35% coinsurance up to maximum copay of $70/Rx	35% coinsurance up to maximum copay of $175/Rx
Non-preferred Brand-name	50% coinsurance up to maximum copay of $120/Rx	50% coinsurance up to maximum copay of $300/Rx

3 *Or the cost of the medication, if less.*

4 *Your copays may be less for generic medications used to treat certain chronic conditions when you complete ActionCards through GPI FIT; refer to the "Schedule of Benefits" for more information.*

Prescription Drug Copays and Coinsurance[1] *Amount You Pay Per Prescription for Covered Medications*		
Drug Class	**Retail Network Pharmacy (up to 30-day supply)**	**Mail Service or Local CVS Pharmacy Store (up to 90-day supply)**
Specialty	$75 copay/Rx only available through CVS Specialty Pharmacy	

1 Or the cost of the medication, if less.

Copays and coinsurance do not apply to covered expenses for certain preventive medications. Refer to "Preventive Medications" for more information.

Other limitations may apply. Refer to "Prescription Drug Coverage" for more information.

PRESCRIPTION DRUG OUT-OF-POCKET LIMIT

The maximum amount that you have to pay out-of-pocket for covered prescription drug expenses in any one calendar year is called your prescription drug out-of-pocket limit. Your out-of-pocket limit for prescription drugs is separate from your out-of-pocket limit for medical.

The prescription drug out-of-pocket limit applies to each family member, with a maximum family out-of-pocket limit equal to two times the individual out-of-pocket limit. The family out-of-pocket limit can be met by expenses from any combination of two or more covered family members.

Prescription Drug Out-of-Pocket Limit *Maximum Amount You Pay Per Calendar Year for Covered Prescription Drugs*		
Your Plan Enrollment	**If You Use a CVS Caremark Network Pharmacy**	**If You Use an Out-of-Network Pharmacy**
HealthPlus Economy PPO **HealthPlus Basic PPO** **HealthPlus Standard PPO** **HealthPlus Premium PPO**	$1,400 individual $2,800 family	Not covered

Once you reach your prescription drug out-of-pocket limit, the plan reimburses up to 100% of covered prescription drug expenses for the remainder of that calendar year. Each January 1, your out-of-pocket limit starts over.

Expenses that are not applied against the prescription drug out-of-pocket limit are:

- Medical expenses. A separate out-of-pocket limit applies for medical. See "Medical Out-of-Pocket Limit" for more information.
- Your share of the cost for prescription drugs administered while confined as an inpatient, in your doctor's office, as part of a home health care treatment or during chemotherapy. These may be covered under the medical provisions of the plan.
- Medications that require prior authorization but for which prior authorization has not been received.
- Medications not covered by the plan.

Maximum Plan Benefits

All HealthPlus PPO medical plans provide unlimited coverage for covered expenses for you and each enrolled family member.

Certain types of care have their own plan maximums, as shown below:

- **Chiropractic care/spinal manipulation.** Benefits for outpatient office visits for chiropractic care and spinal manipulation are limited to 26 visits per person per calendar year, in-network and out-of-network combined.
- **Home health care.** Benefits for home health care are limited to 120 visits per person per calendar year, in-network and out-of-network combined. Visits by an aide solely for home infusion therapy do not count towards this limit.
- **Short term rehabilitative therapy.** Benefits for physical, occupational and speech therapy, collectively, are covered up to 60 visits per person per calendar year, for in-network and out-of-network combined.
- **Travel and lodging for organ transplants.** Benefits for travel (more than 60 miles from home) and lodging for a patient undergoing a transplant and his or her travel companion, are limited to $50 per person per night for the patient who is being evaluated and receiving services, and one companion (when traveling with the patient), or two companions if the patient is a minor child. The combined maximum for all individuals is $10,000. These benefits are only available:
  - For select transplants that have been approved by Anthem BCBS, in advance, and are performed at a Blue Distinction Center.
  - When travel and lodging is approved, in advance by Anthem BCBS.

  See "Organ and Bone Marrow/Stem Cell Transplants" for more information.
- **Travel and lodging for surgery for morbid obesity.** Benefits for travel (more than 60 miles from home) and lodging for a patient undergoing surgery for morbid obesity, are limited to $50 per night up to a maximum of $10,000 per surgery. These benefits are only available:
  - For surgery that has been approved by Anthem BCBS, in advance, and are performed at a Blue Distinction Center.
  - When travel and lodging is approved, in advance by Anthem BCBS.

  See "Surgery for Morbid Obesity" for more information.

Health Reimbursement Account

The HealthPlus HRA is an individual account funded entirely by the Company based on your (and your enrolled spouse's) completion of GPI FIT activities. Money in your HealthPlus HRA can be used to cover your medical, prescription drug, dental and vision out-of-pocket expenses — for you and each family member enrolled in a HealthPlus PPO plan. Outstanding balances at year-end roll over from year to year, provided you continue to be enrolled in a HealthPlus PPO plan.

EARNING HEALTHY REWARDS

IMPORTANT! If you are unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn Healthy Rewards, you may be entitled to a reasonable accommodation or an alternative standard. For more information, call **1-833-862-9191.**

Based on your personal situation, you can choose to complete activities via the "ActionCards" on the GPI FIT website (**www.gpifit.com**), such as:

- Completing a health assessment.
- Seeing your primary care physician for an annual preventive care exam.

- Meeting certain healthy value targets (including non-tobacco use and certain targets for healthy body mass index or waist measurement; blood pressure; and cholesterol).
- Engaging in health coaching.
- Participating in healthy challenges that are communicated throughout the year.

You can access GPI FIT regardless of your medical plan enrollment. However, if you are not enrolled in a Company medical plan, you:

- Will only have access to select ActionCards.
- Will not earn Healthy Rewards.

Get more information about Healthy Rewards:

- Online at **www.gpifit.com** or by calling **1-833-862-9191**. You can learn about:
  - Personalized resources that can help you achieve your health goals.
  - How much you can earn in Healthy Rewards.
  - Which ActionCards are available, which ones allow you to earn Healthy Rewards and which ones you have completed.
- The CaféWell mobile app, available from Google Play or the Apple App Store. Use sponsor code "gpifit" to gain access. The app allows you to:
  - Complete ActionCards with fitness trackers.
  - Track which ActionCards you have completed and which ones remain.
  - Access digital coaching, financial wellness tools, mental health help and much more.
- HealthEquity **(www.myhealthequity.com** or by calling **1-866-346-5800).** You can learn about your HealthPlus HRA, including eligible expenses, claims, account balance and more.

IMPORTANT! Your participation in the GPI FIT program is voluntary and available at no cost to you. Results from your participation are completely confidential and will never be shared with anyone without your permission.

The programs are administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others.

We are required by law to maintain the privacy and security of your personally identifiable health information. Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the GPI FIT program.

VALUE OF HEALTHY REWARDS

If you are enrolled in a HealthPlus PPO medical plan and complete the ActionCards, you can earn up to a total of $1,200 in Healthy Rewards each year; your enrolled spouse can earn a total of $600. Healthy Rewards are deposited into your HealthPlus HRA and can be used to help cover your out-of-pocket health care costs from a GPI health care plan (medical, dental and vision).

The GPI FIT window for earning Healthy Rewards is based on when you first became enrolled in the HealthPlus PPO medical plan and may vary from year-to-year. Annually, the Company will provide you with details on when the window for earning Healthy Rewards begins and when it ends. Refer to your most recent enrollment materials for more details.

USING MONEY IN YOUR HRA

You can use money in your HRA to help cover your out-of-pocket expenses under a GPI medical, dental and vision plan[1].

After processing your claims, Anthem BCBS will send your out-of-pocket expenses (such as deductibles and coinsurance) to HealthEquity. You choose whether you want to use your HealthEquity debit card or request reimbursement through the HealthEquity website to pay for those expenses.

If you do not use all of the money in your HRA during the calendar year, the unused funds will roll over to the following year. Your HRA balance will be forfeited when your coverage ends, unless you elect to continue your coverage under COBRA.

1 *Only out-of-pocket expenses from a GPI medical, dental, and vision plan are eligible for reimbursement from your HRA.*

OTHER INFORMATION

Use of your Healthy Rewards is limited as follows:

- If you are also enrolled in the Company-sponsored health care spending account and use your HealthEquity debit card, claims will be paid from your HealthPlus HRA first. Once your HealthPlus HRA is exhausted, any remaining unpaid portion of covered health care and prescription drug expenses will be paid from available funds in your health care spending account.
- Reimbursement will only be made up to the balance in your account at the time of your claim. If the request is for more than your account balance, an additional payment will be made when sufficient funds are available.
- Charges must be for covered health care and prescription drug expenses provided while you are enrolled in a HealthPlus PPO option.
- Once you receive Healthy Rewards for a specified activity, you cannot receive Healthy Rewards in the same year for repeating that same activity.
- Any balance in your HealthPlus HRA at the end of the year will roll over into the next year, when allowed by the Internal Revenue Service, provided you are enrolled in a HealthPlus PPO option at that time.
- If you are enrolled in a HealthPlus PPO medical plan and elect to enroll in the HealthPlus HSA medical plan during a future enrollment, the balance in your Company-sponsored HRA, if any, will be converted into a "limited purpose" account that can be used for your future out-of-pocket dental and vision expenses, as well as future out-of-pocket medical expenses after you meet the HealthPlus HSA medical plan deductible.
- If you re-enroll in a HealthPlus PPO medical plan after having been enrolled in a HealthPlus HSA plan, the balance in your Company-sponsored limited purpose HRA, if any, will be converted back to a regular HRA.
- If you coverage under a HealthPlus PPO plan ends due to termination of coverage or employment, your participation in the HRA will end. However, if you elect to continue your medical coverage through COBRA, funds in your HRA, if any, will remain available to help cover your eligible out-of-pocket expenses while COBRA is in effect. See your most recent *Benefits Supplement* for more information.
- The HRA is a provision of the HealthPlus PPO medical plans. Healthy Rewards you earn are not vested, portable or guaranteed.

Schedule of Benefits

The plan reimburses services that are specifically listed as a covered expense under the plan. If you have questions about whether a service or supply is covered, call Anthem BCBS Customer Service at **1-855-272-0696** for health care and CVS Caremark at **1-800-774-5780** for prescription drugs — before you receive treatment. You are responsible for any charges that are not covered or reimbursed by the plan.

The plan reimburses a percentage of the maximum allowed amount for covered expenses after the calendar year deductible (where applicable), subject to plan limits. The amount that is reimbursed depends on:

- The option in which you are enrolled.
- Who delivered your care.
- Whether your care was delivered by an in-network provider or out-of-network provider.
- The type of service or supply.
- What you paid for the service or supply.
- The maximum allowed amount.
- Whether the service or supply was medically necessary.

Remember — inpatient stays, surgery, many outpatient procedures and supplies, transplants (including travel and lodging) and certain prescription drugs must be authorized in advance or your charges may not be covered by the plan. See "Prior Authorization" for more information.

The Schedule of Benefits below summarizes your share of the cost for covered services and supplies. All covered services are subject to the terms and provisions of this plan, including exclusions and limitations. See "Covered Services and Supplies" and "What's Not Covered Under the Plan" for more information.

COST SHARING

All four HealthPlus PPO medical options cover the same services. However, the amount you pay and the amount the plan reimburses — the "cost sharing" — is based on the plan you select.

Calendar year deductible

The deductible is the amount you pay each calendar year before the plan begins to share in the cost of covered services

The deductible does not apply to in-network preventive care or prescription drugs (see "Prescription Drugs" for more information)

	HealthPlus Economy PPO *You pay:*	**HealthPlus Basic PPO** *You pay:*	**HealthPlus Standard PPO** *You pay:*	**HealthPlus Premium PPO** *You pay:*
In-network	$5,000 individual; $10,000 family	$2,200 individual; $4,400 family	$1,600 individual; $3,200 family	$1,200 individual; $2,400 family
Out-of-network	$8,000 individual; $16,000 family	$4,400 individual; $8,800 family	$3,200 individual; $6,400 family	$2,400 individual; $4,800 family

COST SHARING (continued)

Coinsurance

This is the percentage of covered charges *you pay* after you have met your calendar year deductible; the plan pays the remaining amount

Note: Covered *in-network* preventive care is covered at 100% by the plan with no deductible; prescription drugs may be covered differently (see "Prescription Drugs" for more information)

	HealthPlus Economy PPO *You pay:*	**HealthPlus Basic PPO** *You pay:*	**HealthPlus Standard PPO** *You pay:*	**HealthPlus Premium PPO** *You pay:*
In-network	50% coinsurance	30% coinsurance	20% coinsurance	10% coinsurance
Out-of-network	70% coinsurance	50% coinsurance	40% coinsurance	30% coinsurance

Calendar year out-of-pocket limit

This is the maximum you pay in a calendar year for covered services (including your deductible)

Once you reach your out-of-pocket limit, the plan reimburses 100% of eligible expenses for the remainder of the calendar year

	HealthPlus Economy PPO *You pay:*	**HealthPlus Basic PPO** *You pay:*	**HealthPlus Standard PPO** *You pay:*	**HealthPlus Premium PPO** *You pay:*
In-network: medical	$6,500 individual; $13,000 family	$5,200 individual; $10,400 family	$4,600 individual; $9,200 family	$4,200 individual; $8,400 family
In-network: prescription drug	$1,400 individual; $2,800 family	$1,400 individual; $2,800 family	$1,400 individual; $2,800 family	$1,400 individual; $2,800 family
Out-of-network: medical only *Prescription drugs and certain medical services are not covered out-of-network*	$13,000 individual; $26,000 family	$10,400 individual; $20,800 family	$9,200 individual; $18,400 family	$8,400 individual; $16,800 family
Lifetime coverage limit	No lifetime maximum limit, however annual or visit limits may apply to certain services			
Health reimbursement account (HRA)	• GPI contributes to your HRA; the amount is based on completion of certain GPI FIT ActionCards during the GPI FIT earning window • You can earn up to $1,200 (for you) and $600 (for your enrolled spouse) • You (and your spouse, as applicable) must be enrolled in a HealthPlus PPO medical plan to earn Healthy Rewards			

OUTPATIENT SERVICES

Office Visits

Primary doctor office visit, specialist office visit, allergy tests and treatments	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible

OUTPATIENT SERVICES (continued)	
LiveHealth Online *www.livehealthonline.com*	In-network — You pay $59/visit (applied toward your calendar year deductible); then plan coinsurance after calendar year deductible is met Out-of-network — Not available
Preventive Care *Covered services are based on age and frequency guidelines developed by a national panel of health care experts; visit* **www.anthem.com/preventive-care** *or contact Anthem BCBS at* **1-855-272-0696** *for information*	
Annual routine physical exam *Age 19 and older*	In-network — 100% covered, no deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Well woman exam	In-network — 100% covered, no deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Routine mammogram	In-network — 100% covered, no deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Well child exam *Children through age 18*	In-network — 100% covered, no deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Immunizations *Adult and child; immunizations for travel not covered*	In-network — 100% covered, no deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Cancer screenings	In-network — 100% covered, no deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Cardiovascular screenings *Not covered unless part of routine annual physical exam*	In-network — 100% covered, no deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Outpatient Care	
Outpatient surgery: facility, surgeon, anesthesiologist, assistant surgeon *Prior authorization required on many outpatient procedures*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible *Assistant surgeon and anesthesiologist covered at in-network levels — even if not in Anthem BCBS network — if surgery performed at an in-network facility; prior authorization required*
Outpatient x-ray, radiology and laboratory *Prior authorization required on certain procedures*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible

OUTPATIENT SERVICES (continued)	
Outpatient physical therapy, occupational therapy, speech therapy *Limited to 60 visits per calendar year, combined*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Hearing screening *Limited to one screening per calendar year; exams not covered*	In-network — 100% covered, no deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Hearing aids	Not covered
Routine vision screening *Limited to one screening per calendar year; exams not covered*	In-network — 100% covered, no deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Regular lenses and frames; contact lenses	Not covered *Initial lens following cataract surgery may be covered; check with Anthem BCBS for details*
Dental implants	Not covered
Accidental injury to natural teeth; surgical removal of oral tumors, cysts *Check with Anthem BCBS for details*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible
FAMILY PLANNING/MATERNITY CARE	
Prenatal office visits, doctor charges for delivery, postnatal office visits	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible
In-hospital delivery services *Prior authorization required for extended stays*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Newborn nursery *Covered under mother's benefit for well newborn while mother is also confined; child must be eligible and enrolled within 31 calendar days after birth for plan to consider (1) doctor charges for well newborn, or (2) facility and doctor charges for sick newborn*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Fertility services *Limited to diagnosis and treatment of underlying cause; check with Anthem BCBS for details*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible

FAMILY PLANNING/MATERNITY CARE (continued)	
In vitro fertilization, artificial insemination	In-network — Not covered Out-of-network — Not covered
Female tubal ligation *Reversal not covered; check with Anthem BCBS for details*	In-network — 100% covered, no deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Male vasectomy *Reversal not covered; check with Anthem BCBS for details*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible
INPATIENT SERVICES **Inpatient Room and Board:** *Includes semi-private room; general nursing care; intensive care (and other special care units); operating, recovery and treatment rooms; prescription drugs; supplies; lab and x-ray diagnostic imaging provided during a covered hospital stay* **Prior authorization:** *Required*	
Hospital semi-private room	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Inpatient lab and x-ray	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Inpatient doctor, surgeon, assistant surgeon and anesthesiologist	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible *Assistant surgeon and anesthesiologist covered at in-network levels — even if not in Anthem BCBS network — if surgery performed at an in-network facility*
EMERGENCY CARE *Contact Anthem BCBS at* **1-855-272-0696** *within two business days after receiving emergency treatment*	
Emergency room, emergency room doctor *Limited to medical and accident emergencies*	In-network and out-of-network — You pay in-network plan coinsurance after calendar year deductible
Urgent care clinic visit	In-network and out-of-network — You pay in-network plan coinsurance after calendar year deductible
Ambulance services *Limited to medical and accident emergencies; prior authorization required for air ambulance*	In-network and out-of-network — You pay in-network plan coinsurance after calendar year deductible

PRESCRIPTION DRUGS: IN-NETWORK ONLY **Prior authorization:** *Required for certain medications* **Note:** *Prescription medications administered while confined as an inpatient, in your doctor's office, as part of a home health care treatment or during chemotherapy generally are covered under the medical provisions of the plan administered by Anthem BCBS*	
Calendar year prescription deductible	None
Calendar year out-of-pocket maximum	$1,400 individual; $2,800 family
Out-of-network coverage	None
Reduced copays for certain maintenance medications	Your copay for **generic medications** used to treat *asthma, diabetes, chronic obstructive pulmonary disease, congestive heart failure, coronary heart disease, hypertension or high cholesterol* will be waived after you complete certain online ActionCards through GPI FIT; annual participation required; visit **www.gpifit.com** or call **1-833-862-9191** for more information While your coinsurance/copay does not change, the total cost for **brand-name medications** used to treat *diabetes, heart disease, high blood pressure and high cholesterol* will be reduced by 50%, resulting in a lower cost to you Maintenance prescriptions must be filled through the CVS Caremark network; only the initial prescription and one 30-day refill are covered at retail network pharmacies; thereafter the prescription must be filled through the CVS Caremark "Maintenance Choice" program (see below)
Preventive medications	No copay or coinsurance for preventive medications; the listing changes periodically based on federal guidance; call CVS Caremark at **1-800-774-5780** for more information
Retail: Up to 30-day supply: in-network only **Mandatory generic:** *You pay brand-name coinsurance plus difference in cost between brand-name and generic if Rx filled with brand-name drug — when generic drug is available*	
Retail generic	You pay $7.50 copay per Rx (or cost of Rx, if less)
Retail preferred brand-name *CVS Caremark Performance Drug List*	You pay 35% coinsurance, up to $70 maximum copay per Rx
Retail non-preferred brand-name	You pay 50% coinsurance, up to $120 maximum copay per Rx
Maintenance Choice: Mail Service or Local CVS Pharmacy Store: 90-day supply *Medications filled through the Maintenance Choice program are only available in 90-day fill through the Mail Service Pharmacy or your local CVS Pharmacy store after the initial fill and one 30-day refill at a retail network pharmacy* **Mandatory generic:** *You pay brand-name coinsurance plus difference in cost between brand-name and generic if Rx filled with brand-name drug — when generic drug is available* **Mandatory mail:** *For long term medications, plan covers initial prescription and one 30-day refill at local network pharmacy; mandatory mail through CVS Caremark Mail Service Pharmacy thereafter (except for controlled substances and specialty drugs) or refill through local retail CVS Pharmacy store.* **Note:** *Controlled substances that cannot be distributed by mail must be filled through a local retail CVS Caremark network pharmacy*	
Mail service generic	You pay $18.75 copay per Rx (or cost of Rx, if less)

PRESCRIPTION DRUGS: IN-NETWORK ONLY (continued)	
Mail service preferred brand-name *CVS Caremark Performance Drug List*	You pay 35% coinsurance, up to $175 maximum copay per Rx
Mail service non-preferred brand-name	You pay 50% coinsurance, up to $300 maximum copay per Rx
Specialty Drugs *For chronic and/or genetic conditions, requiring special pharmacy products, often in the form of injected or infused medications; all prescriptions must be filled through CVS Specialty Mail Pharmacy (**1-800-237-2767**); up to a 30-day supply*	
Specialty drugs	You pay $75 copay per Rx (or cost of Rx, if less)
Other	
Oral contraceptives	Retail and mail order available; retail for initial prescription plus one refill; mail order thereafter; 100% covered, no copay, for generic and single-source brand-name contraceptive prescriptions; multi-source brand-name subject to copays
Fertility drugs	Not covered
Diabetic medications	Only available through the Mail Service or local CVS Pharmacy Store
OTHER SERVICES	
Mental health and substance abuse **Prior authorization:** *Required for all inpatient stays, partial hospitalizations, intensive outpatient therapy and residential care*	
Inpatient and outpatient coverage	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Alternative Care	
Chiropractic care and spinal manipulation *Limited to 26 visits per calendar year*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Acupuncture *Not covered; unless performed by network provider as form of anesthesia for covered surgery*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Other	
Dialysis *See "Inpatient Services" for coverage while hospital confined*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible

OTHER SERVICES (continued)	
Chemotherapy, radiation therapy *Prior authorization required* *See "Inpatient Services" for coverage while hospital confined*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Cardiac, pulmonary and respiratory therapy *See "Inpatient Services" for coverage while hospital confined; limitations exist; check with Anthem BCBS before you begin a course of treatment*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Noncustodial home health care *Limited to 120 visits per calendar year* *Visit limit does not include visits solely for home infusion therapy*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Hospice care *Limited to care during final stages of terminal illness*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Prescribed care in noncustodial skilled nursing facility *Prior authorization required*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Durable medical equipment and disposable medical supplies *Prior authorization required for durable medical equipment*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Prosthetic devices *Prior authorization required*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible
Gender affirming surgery *Prior authorization required*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — You pay plan coinsurance after calendar year deductible
HUMAN ORGAN AND BONE MARROW/STEM CELL TRANSPLANTS: IN-NETWORK ONLY ***Prior authorization:*** *Required; certain transplants must be performed at a Blue Distinction Center*	
Inpatient care *Prior authorization required*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — Not covered

HUMAN ORGAN AND BONE MARROW/STEM CELL TRANSPLANTS: IN-NETWORK ONLY (continued) ***Prior authorization:*** *Required; certain transplants must be performed at a Blue Distinction Center*	
Travel and lodging *Prior authorization required; only available for transplants required by the plan to be performed at a Blue Distinction Center* *Up to $10,000 allowance for yourself and one companion (or two companions if the patient is a minor child)* *Limitations exist; see "Organ and Bone Marrow/Stem Cell Transplants" for more details*	In-network — You pay plan coinsurance after calendar year deductible Out-of-network — Not covered
CARE MANAGEMENT PROGRAMS	
Future Moms Maternity	Individual care and support for pregnant moms; call Anthem BCBS at **1-800-828-5891** for details
24/7 NurseLine	Individual teleconference guidance with a registered nurse; call Anthem BCBS at **1-800-700-9184** for details
ComplexCare	Individual support and education for those with multiple health issues; call Anthem BCBS at **1-855-272-0696** for details
Teladoc Medical Experts	Free, confidential support for a wide range of medical conditions including everything from back pain and sports injuries to a cancer diagnosis; call **1-800-TELADOC (835-2362)** for details
Solera Diabetes Prevention Program	A no-cost 16-week program to help you lose weight, adopt healthy habits and reduce the risk of developing diabetes. Includes online or in-person options; determine your risk and see if you qualify by visiting **www.solera4me.com/gpi** or **texting "gpi" to 81053**
Clickotine Tobacco Cessation Program	Free help with quitting tobacco use for you and your spouse; download the Clickotine mobile app by visiting **www.MagellanAscend.com** or call **1-800-327-9781** for more information on how to access the app

Covered Services and Supplies

Subject to the terms of the plan, the following services and supplies may be covered expenses after your share of the cost, as shown in the Schedule of Benefits.

Acupuncture

The plan covers acupuncture when delivered by a provider as a form of anesthesia for a surgical procedure covered by this plan.

Ambulance Service

IMPORTANT! Be sure to contact Anthem BCBS at **1-855-272-0696** within two business days after receiving any emergency treatment. If you cannot make the call, your doctor, a family member or friend can make the call for you.

The plan covers transportation by a licensed ambulance service for basic or advanced life support during a "medical emergency." Transportation by ambulance, including air ambulance, for a non-medical emergency is subject to prior authorization by Anthem BCBS.

Coverage only applies for medically necessary transport to:

- The nearest facility equipped to stabilize and initiate treatment under the direction of a doctor in an emergency situation.
- A hospital at the next level of acute care (for example to a rehabilitation facility), when the transportation is medically necessary based on the patient's condition.

The plan does not cover transport to and from a custodial care facility or transport to and from home. In addition, the plan does not cover air ambulance, unless deemed to be medically necessary by Anthem BCBS because of the distance involved or because the covered patient has an unstable condition requiring medical supervision and rapid transport.

A medical emergency is defined as an accidental traumatic bodily injury or other medical condition that has sudden acute symptoms of such severity (including severe pain) that, if left untreated, would cause a layperson to believe that failure to seek immediate care in an emergency room could:

- Place the person's health in serious jeopardy.
- Lead to serious impairment to bodily function or dysfunction of a body part or organ.
- In the case of a pregnant woman, result in serious jeopardy to the health of the mother and/or fetus.

Examples of medical emergencies include heart attack or suspected heart attack, poisoning, severe shortness of breath, uncontrolled or severe bleeding, suspected overdose of medication, severe burns, high fever (especially in infants) and loss of consciousness.

Anesthesia

The plan covers anesthesia, provided it is administered and billed by a doctor (other than the operating surgeon or surgical assistant) or a certified registered nurse anesthetist.

Charges billed by an out-of-network anesthesiologist for medically necessary surgery received at an in-network facility may be covered at the in-network level.

Chemotherapy and Radiation Therapy

IMPORTANT! Prior authorization may be required. Contact Anthem BCBS at **1-855-272-0696** in advance of receiving your care. See "Prior Authorization" for more information.

The plan covers the administration of chemotherapy agents approved by the U.S. Food and Drug Administration (FDA) and radiation therapy (such as x-ray, radium and radioactive isotope therapy) for participants who have been diagnosed with cancer.

Chiropractic Care and Spinal Manipulation

The plan covers chiropractic care (including spinal manipulation) — up to 26 visits per person each calendar year, in-network and out-of-network combined.

Care is limited to medically necessary manipulations with any covered provider. Maintenance care is not covered.

Contraceptives

Covered expenses for non-oral forms of contraceptives are based on the type of contraceptive and from whom the non-oral contraceptive is purchased. In some cases, a doctor's prescription may be required.

Oral forms of contraceptives may be covered under the prescription drug provisions of the plan. See "Prescription Drug Coverage" for more information.

Dental Care

The plan covers treatment to repair sound natural teeth that are injured as a result of an accident (other than biting, chewing or other normal daily living activities), provided such services are delivered within 12 months from the date of the accident. Coverage is limited to the initial treatment (or course of treatment) and/or initial restoration, including reimplantation of original sound natural teeth, crowns, fillings and bridges.

The plan also covers the following services:

- Excision of a tumor or cyst, or incision and drainage of an abscess or cyst.
- Treatment of cleft lip and cleft palate.
- Any oral surgical procedure not involving any tooth structure, alveolar process or gingival tissue.

Diagnostic X-ray, Radiology and Lab

IMPORTANT! Prior authorization may be required. Contact Anthem BCBS at **1-855-272-0696** in advance of receiving your care. See "Prior Authorization" for more information.

The plan covers diagnostic x-rays, radiology services, therapeutic treatments and laboratory testing. Diagnostic services are tests or procedures generally performed when you have specific symptoms to detect or monitor your condition.

Diagnostic services include, but are not limited to, the following:

- Laboratory and pathology services.
- X-ray and other radiology services.
- EKGs, MRIs, MRAs, CT scans and PET scans.
- Imaging cardiac stress tests (nuclear cardiology, Myoview, myocardial perfusion scan or cardiac echo stress test).
- Encephalographic and radioisotope tests.
- Ultrasound services.
- Allergy tests.
- EKGs and echocardiograms.
- Bone density studies.

Some procedures may be covered as preventive care. See "Preventive Care for Adults" and "Well Child Care" for more information.

Dialysis

The plan covers services and supplies for participants who have been diagnosed with end stage renal disease, including hemodialysis and peritoneal dialysis.

Durable Medical Equipment and Disposable Supplies

IMPORTANT! Prior authorization is required for durable medical equipment. Contact Anthem BCBS at **1-855-272-0696** in advance of receiving your care. See "Prior Authorization" for more information.

The plan covers the rental and repair of medically necessary **durable medical equipment**, provided the equipment is authorized by Anthem BCBS in advance.

If long term care is planned and/or (1) rental is not available, or (2) purchase is more cost effective, the plan will cover the cost for purchasing the equipment.

Durable medical equipment includes, but is not limited to:

- Ventilators.
- Oxygen concentrator units and equipment rental to administer oxygen.
- Continuous positive airway pressure (CPAP) devices.
- Braces that stabilize an injured body part.
- Braces to treat curvature of the spine.
- Standard hospital beds.
- Wheelchairs.
- Foot orthotics, but only for certain conditions and when strict criteria are met. Contact Anthem BCBS for more information.

The plan also covers the replacement of purchased equipment, when needed due to a change in the person's physical condition — provided it is more cost effective than renting or repairing the equipment.

The purchase of **disposable medical supplies** may be covered. This includes, but is not limited to:

- Burn garments.
- Compression stockings when used for care related to the diagnosis of lymphedema.
- Delivery pumps for tube feeding.
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions.
- Ostomy and colostomy supplies and apparatus.
- Surgical stockings (when medically necessary).
- Nebulizers.
- Nasal cannulas, connectors and masks that are used with durable medical equipment.
- Surgical dressings, casts, splints, trusses and crutches.

To be considered a covered expense, the equipment or supply must:

- Be ordered or provided by a doctor for outpatient use.
- Perform the necessary function.
- Withstand repeated use (other than disposable supplies).
- Not be of use to a person in the absence of an illness or disability.
- Be appropriate for use in the home.

Rental or purchase of a breast pump for women who are breast-feeding their newborn child is covered as part of preventive care. See "Preventive Care for Adults" for more information.

Emergency Care

IMPORTANT! Be sure to contact Anthem BCBS at **1-855-272-0696** within two business days after receiving any emergency treatment. If you cannot make the call, your doctor, a family member or friend can make the call for you.

The plan covers emergency care to stabilize or initiate treatment for an illness or injury.

Care can be delivered in any of the following:

- An ambulatory care center.
- An urgent care center.
- A hospital emergency room.

The plan covers care for the facility and all related professional charges, such as radiology, pathology and emergency room doctor.

Services received at an emergency room are covered only if you have a "medical emergency." A medical emergency is defined as an accidental traumatic bodily injury or other medical condition that has sudden acute symptoms of such severity (including severe pain) that, if left untreated, would cause a layperson to believe that failure to seek immediate care in an emergency room could:

- Place the person's health in serious jeopardy.
- Lead to serious impairment to bodily function or dysfunction of a body part or organ.
- In the case of a pregnant woman, result in serious jeopardy to the health of the mother and/or fetus.

Examples of medical emergencies include heart attack or suspected heart attack, poisoning, severe shortness of breath, uncontrolled or severe bleeding, suspected overdose of medication, convulsions, severe burns, high fever (especially in infants) and loss of consciousness.

Non-emergency use of the emergency room, as determined by Anthem BCBS, is not covered. This would include follow-up care done in an emergency room (for example, wound checks and suture removal).

Home Health Care

The plan covers skilled medical services provided by an approved home health care agency — up to 120 visits per person each calendar year, in-network and out-of-network combined.

To be considered, the services must be:

- Medically necessary for the treatment of an illness or injury.
- Ordered by a doctor.
- Provided by a home health aide or licensed practical nurse.
- Provided in the patient's home.
- Documented in a home health care plan.

Home health care benefits are limited to those charges delivered and billed by a home health care agency for the following:

- Visits for physical, occupational or speech therapy by licensed therapists.
- Medical supplies and appliances, prescription drugs and lab services which are prescribed by a licensed doctor and would have been payable as a covered hospital benefit if the participant had been confined as an inpatient in a hospital.
- Home infusion therapy (such as total parenteral nutrition, enteral nutrition therapy, antibiotic therapy, pain management and chemotherapy) when delivered by a home infusion provider.
- Visits for nursing care by a nurse.
- Home health care aide services providing supportive services in the home under the supervision of a nurse or licensed therapist.

Each session of care by a therapist, nurse or home health care aide is counted as one visit. Visits solely for home infusion therapy are not subject to the 120-visit limit.

Care that is solely provided to assist the patient with activities of daily living, such as dressing, feeding, bathing or transferring from bed to chair and back, are not covered by the plan. In addition, services that can be safely and effectively provided by a layperson or self-administered without the direct supervision of a licensed nurse are not covered by the plan, even if performed by the home health care agency.

Hospice Care

The plan covers care when received through a recognized hospice care program. Hospice benefits are provided for medically necessary care (both inpatient and outpatient) and supportive services during the final stages of terminal illness for you or a covered family member.

Benefits provided during the last six months of life expectancy for both inpatient and outpatient care include:

- Hospice facility charges — not to exceed the hospital's most common semi-private room rate.
- Routine and continuous home nursing care, home health aide visits, physical therapy, speech therapy and occupational therapy visits.
- Medical supplies, prescription drugs (when delivered and billed by the hospice) and lab services which are prescribed by a licensed doctor.
- Medical social services, under the direction of a doctor, to assess the patient's status, identify possible community resources, and assist in obtaining those resources.
- Pain management and symptom control.
- Psychological, dietary and bereavement counseling.

The plan does not cover the following charges made by a hospice:

- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling, including estate planning and drafting of a will.
- Services which are not solely for the care of the patient.
- Respite care.

The Company's EAP, available 24 hours a day, 7 days a week, can provide additional emotional support and assistance locating community resources. Call **1-800-327-9781** for more information.

Infertility Coverage

The plan covers services provided to diagnose and treat the underlying medical conditions of infertility. Infertility services are available to all female participants, based on the terms of the plan.

You can obtain the following diagnostic infertility services from an obstetrician or infertility specialist:

- Initial evaluation, including history, physical exam and lab studies performed at an appropriate network lab.
- Evaluation of ovulatory function.
- Ultrasound of ovaries.
- Postcoital test.
- Hysterosalpingogram.
- Endometrial biopsy.
- Hysteroscopy.

The plan covers treatment for the underlying medical conditions only; artificial insemination, in-vitro fertilization, gamete intrafallopian tube transfer (GIFT) and zygote intrafallopian tube transfer (ZIFT) and any other forms of infertility treatments, including all related charges, are not covered benefits under this plan.

Inpatient Care in a Hospital or Other Facility

IMPORTANT! Prior authorization is required for all inpatient confinements. Call Anthem BCBS at **1-855-272-0696** at least 10 days prior to your admission. See "Prior Authorization" for more information.

The plan covers inpatient care in a hospital or other health care facility, provided your stay is authorized by Anthem BCBS in advance of your admission.

The types of services covered while confined as an inpatient in a hospital or other facility are:

- Room and board for the most common semi-private room rate. If you must be in a private room because of contagious disease or some other medical reason, or because a semi-private room is not available, the lowest private room and board rate will be covered.
- Intensive care, intensive cardiac care and other specialty care units.
- General nursing services.
- Use of operating rooms, maternity delivery rooms, recovery rooms, treatment rooms and equipment, where appropriate.

- Eligible prescription drugs and medicines administered during your hospital stay.
- Nursery charges for care of a newborn, provided the newborn is enrolled in the Company plan. See "Maternity Coverage" and your most recent *Benefits Supplement* for more information.
- Administration of blood and blood plasma.
- Oxygen, including oxygen administration and other gas therapies.
- Intravenous injections and solutions.
- Anesthesia, including anesthesia administration.
- Lab, x-rays and other radiology exams and tests.
- Therapeutic services, such as physical, occupational and speech therapy; and cardiac, respiratory and pulmonary rehabilitation.
- Chemotherapy and radiation therapy, and similar medically necessary treatments.
- Diagnostic imaging tests, including EKGs, MRIs, MRAs, CT scans and PET scans.
- Dressings, ordinary splints and casts.

To qualify, the institution must be licensed in accordance with the laws of the state in which it is located and:

- Maintain inpatient facilities for bed care of resident patients.
- Have a doctor in regular attendance.
- Provide 24-hour-per-day nursing services by registered nurses.
- With respect to a medical/surgical hospital only — have facilities for major surgical operations, x-rays and lab tests.

If you have an emergency, seek care from the nearest emergency room. Then, contact Anthem BCBS within two business days after receiving treatment. If you cannot make the call, your doctor, a family member or friend can make the call for you.

Maternity Coverage

IMPORTANT! Prior authorization may be required. Contact Anthem BCBS at **1-855-272-0696** in advance of receiving your care. See "Prior Authorization" for more information.

The plan covers doctor's fees for pre-natal care, delivery and post-natal care. It also covers the most common semi-private room and board rate and other eligible hospital charges for medically necessary confinements. Maternity benefits are available to all female participants.

For routine vaginal deliveries, the plan automatically will cover up to 48 hours in a hospital following delivery. For cesarean section deliveries, the plan automatically will cover up to 96 hours in a hospital following delivery. Your stay may be shorter if you and your doctor agree on a shorter stay. However, if your provider determines that a longer stay is required for either the mother or the baby, you must contact Anthem BCBS for prior authorization or benefits for the extended stay may be denied.

Benefits are also provided for:

- A birthing center.
- The services of a nurse midwife provided the nurse midwife is licensed in accordance with the laws of the state in which the care and delivery occur.

COVERAGE FOR YOUR NEWBORN CHILD

The **hospital nursery** charges for a **well newborn child** are covered as part of the mother's benefit while the mother is in the hospital.

For **other charges** to be considered, your child must be eligible under the terms of the plan and enrolled for coverage within 31 days after birth. These charges can include:

- A doctor's examination of your well newborn child prior to discharge from the hospital.
- Professional and facility charges for a sick newborn child, regardless of whether the mother is confined.
- Continued hospitalization of the newborn child after the mother is discharged, provided the stay is authorized, in advance, by Anthem BCBS.

IMPORTANT! To enroll your newborn child, visit the Your Benefits Resources website at **www.ybr.com/gpi** or call the Your Benefits Resources Customer Service Center at **1-800-201-6885**. After enrolling, you will receive a request for documentation of the child's birth and relationship to you. Documentation, listing you as the child's parent, can be a birth certificate from the hospital or state in which the child was born.

Doctor, professional and facility charges for a sick newborn and any charges for an extended hospital stay for the child will not be covered by this plan if:

- The child is not eligible for enrollment in the plan (for example, the newborn child is your grandchild).
- You do not enroll your eligible child within 31 calendar days after birth.
- You do not provide documentation by the deadline.

Refer to your most recent *Benefits Supplement* for more details on eligibility and enrollment requirements.

Mental Health and Substance Abuse Coverage

IMPORTANT! All inpatient care and alternatives to inpatient care must be authorized, in advance, by Anthem BCBS. Call **1-855-272-0696** at least 10 days prior to your admission. See "Prior Authorization" for more information.

The plan covers services provided for the treatment of mental health and substance abuse conditions, including:

- Office visits for evaluation, crisis intervention and treatment of mental and nervous disorders as described in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
- Inpatient care in a hospital, when medically necessary.
- Care in a licensed residential treatment facility, when the facility provides overnight services for individuals who do not require acute inpatient care but who do need 24 hour medical supervision.
- Alternatives to inpatient care, such as outpatient therapy or partial hospitalization.

If you have an emergency, seek care from the nearest emergency room. Then, contact Anthem BCBS within two business days after receiving treatment. If you cannot make the call, your doctor, a family member or friend can make the call for you. All emergency care is subject to review by Anthem BCBS for medical necessity.

The Company's EAP, available 24 hours a day, 7 days a week, can may be able to provide immediate short-term support. See "Employee Assistance Plan" or call **1-800-327-9781** for more information.

AUTISM SPECTRUM DISORDER

IMPORTANT! Prior authorization may be required for certain services used for treatment of autism spectrum disorder, including applied behavioral analysis or therapy. Contact Anthem BCBS at **1-855-272-0696** in advance of receiving your care. See "Prior Authorization" for more information.

The plan covers services for participants who have been diagnosed with an autism spectrum disorder.

Covered services include the following:

- Office visits for assessments, evaluations and tests required to diagnose autism spectrum disorder.
- Professional psychiatric and psychological services and treatment programs.
- Applied behavioral analysis or applied behavioral therapy, when prior authorization has been requested and approved by Anthem BCBS in advance of receiving care.
- Speech therapy, occupational therapy and physical therapy. See "Short Term Rehabilitation Services" for more information.

Outpatient Provider Services

The plan covers care delivered in a health care provider's office for:

- Office visits (health exams and routine physicals are covered only as allowed under "Preventive Care for Adults" and "Well Child Care").
- Minor surgery.
- Injections for covered medications, including non-oral forms of contraceptives, such as Depo-Provera and diaphragm fittings (immunizations, other than for travel, are covered only as allowed under "Preventive Care for Adults" and "Well Child Care").
- Allergy testing, serum, and injections administered by a health care professional that are not self-injectable.
- Care or consultation by a specialist.
- Lab tests.

Office visits to a primary care physician for treatment of attention deficit hyperactivity disorder, attention deficit disorder or a similar condition, are limited to the initial visit to diagnose the condition, as well as periodic visits with a primary care physician for renewal of any required prescription medications.

Outpatient Surgery

IMPORTANT! Many outpatient surgeries must be authorized, in advance, by Anthem BCBS. Call **1-855-272-0696** at least 10 days prior to your surgery. See "Prior Authorization" for more information.

The plan covers physician services and the charges for an outpatient surgical facility (other than a doctor's office) — for medically necessary surgery.

Preadmission Testing

The plan covers diagnostic lab work and x-rays performed on an outpatient basis before your hospital admission.

To qualify for coverage, the tests must be:

- Accepted by the hospital at which you will be confined.
- Performed in place of the tests that normally would have taken place during your hospital confinement.
- Prescribed by either the doctor who scheduled the hospital confinement, or the doctor caring for you while you are in the hospital.

Preventive Care for Adults

When provided by an Anthem BCBS network provider and based on the guidelines noted below, the plan covers the full cost for certain preventive health services for participants age 19 and older. Preventive services delivered by out-of-network providers are subject to the plan's deductible and coinsurance requirements. (For preventive care for children under age 19, see "Well Child Care.")

To qualify, the services must comply with the Preventive Medicine Guidelines that comprise the Anthem BCBS Medical Policy. These Guidelines adopt the services recommended by several federal government and/or independent agencies responsible for the development and monitoring of preventive care. Many of the Guidelines take into account gender, age and your family's medical history. For more information about what is covered, visit **www.anthem.com/preventive-care/** and select the guideline that you want to view or call Anthem BCBS Customer Service at **1-855-272-0696**.

The types of services that are covered as preventive health care for adults include but are not limited to:

- Adult routine physical exams.
- Routine screenings such as blood pressure, cholesterol, diabetes, colonoscopy and prostate-specific antigen (PSA) test.
- Bone density tests.
- Screening for depression and obesity.
- Obesity counseling.
- Routine immunizations (other than for travel), including hepatitis A; hepatitis B; herpes zoster; quadrivalent human papillomavirus vaccine; influenza; measles, mumps and rubella, varicella; meningococcal; pneumococcal; and tetanus, diphtheria and pertussis; and COVID-19.
- Routine vision screening — but not exams— up to one screening every calendar year, limited to:
  - Visual acuity tests.
  - Color blindness tests.
  - Cover testing to test for proper eye coordination.
  - Slit-lamp examination to examine the health of the eyes.
  - Pupil dilation to view the eye's internal structures.
  - Glaucoma testing.
  - Visual field testing for peripheral vision.

  The plan does not cover refractions, retinoscopy, autorefractors/aberrometers, fitting of contact lenses and laser retina scans as part of any vision screening.
- Routine hearing screening — but not exams — up to one screening every calendar year.

WELL WOMAN CARE

In addition, the following well woman care is covered, subject to the Preventive Medicine Guidelines:

- Well woman gynecological exams.
- Routine screenings such as mammography and pap smear.
- Breastfeeding support, supplies and counseling, including rental or purchase of a breast pump for women who are breast-feeding their newborn child.
- Gestational diabetes screening.
- Domestic violence screening and counseling.
- HPV screening.
- Sexually transmitted infection counseling.
- HIV screening and counseling.
- Certain FDA-approved contraceptive methods, including sterilization procedures and patient education/counseling for a woman with reproductive capacity for the following:
  - Diaphragms (including the cost of the device and charge for fitting — when billed through a doctor's office[1]).
  - Implantable and injectable contraceptives.
  - Tubal ligation procedure.
  - Intrauterine devices (IUDs), including the cost of the device and charge for placement or removal — when billed through a doctor's office[1].

1 These may be covered under the prescription drug portion of the plan when purchased through a CVS Caremark network pharmacy. See "Prescription Drug Coverage" for more information.

Prosthetic Devices and Appliances

IMPORTANT! Prior authorization is required for prosthetic devices and appliances. Contact Anthem BCBS at **1-855-272-0696** in advance of receiving your care. See "Prior Authorization" for more information.

The plan covers medically necessary, original prosthetic devices and appliances, including artificial limbs, artificial eyes and breast implants (following surgery for breast cancer only).

Repairs (if more cost effective than replacement) and replacements of approved devices and appliances also are covered when medically necessary due to biological changes or normal wear and tear. The plan's coverage includes initial contact lenses prescribed immediately following cataract surgery.

Short Term Rehabilitation Therapy

The plan covers short term rehabilitation services provided certain conditions are met. For more information about what is covered under the plan call Anthem BCBS Customer Service at **1-855-272-0696**.

PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY

The plan covers short-term outpatient rehabilitation for physical, occupational or speech therapy when recommended by a doctor and performed by a licensed registered therapist. Benefits are limited to 60 visits per person each calendar year for all services collectively, in-network and out-of-network combined.

Speech therapy is considered by the plan only when medically necessary to restore speech that has been lost due to illness or injury or for a child diagnosed with autism spectrum disorder. The plan does not cover speech therapy for a child whose speech development was delayed or suppressed due to developmental delays or because of an illness or injury before the child developed any functional speech.

CARDIAC, PULMONARY AND RESPIRATORY REHABILITATION

The plan covers short-term outpatient rehabilitation for cardiac, pulmonary (for treatment of reversible pulmonary disease only) and respiratory therapy when:

- Recommended by a doctor and performed by a licensed registered therapist.
- The services are expected to result in significant physical improvement of your condition.
- The services are not provided to maintain a level of functioning or to prevent a medical condition from occurring or recurring.

Cardiac rehabilitation may be considered for care following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction.

Skilled Nursing Facility Care

IMPORTANT! All inpatient care must be authorized, in advance, by Anthem BCBS. Call **1-855-272-0696**. See "Prior Authorization" for more information.

The plan covers care received at a skilled nursing facility if you are convalescing from an injury or illness that requires a combination of skilled nursing, rehabilitation and facility services that are less than those of a general acute hospital but more than those available in a home setting.

Eligible charges include:

- Room and board for the most common semi-private room rate.
- General nursing services.
- Use of special treatment rooms and equipment, where appropriate.
- Eligible drugs and medicines used during your confinement.
- Administration of blood and blood plasma.
- Oxygen, including oxygen administration, and other gas therapies.
- Intravenous injections and solutions.
- Lab, x-rays and other radiology exams and tests.
- Therapeutic services, such as physical, occupational and speech therapy; cardiac, respiratory and pulmonary rehabilitation.
- Other medical services given in a skilled nursing facility (excluding private duty nursing).
- Medical supplies.

Your doctor must order the confinement and certify that the care is medically necessary as a part of your treatment. Benefits will not be provided for custodial care, or if the patient cannot significantly improve from continuing treatment in the skilled nursing facility.

The plan will not cover confinement in a skilled nursing facility for:

- Treatment of substance abuse (alcohol and/or drug), chronic brain syndrome, senility, mental retardation or any other mental disorder.
- Nursing care provided for skilled observation.
- Nursing care to administer routine maintenance medications or oral medications.
- Custodial care for daily life activities, such as meal preparation, dressing, feeding, bathing or transferring from bed to chair and back, etc.
- Services that can be safely and effectively performed by a layperson or self-administered without the direct supervision of a licensed nurse.

Surgical Procedures

IMPORTANT! Many surgical procedures must be authorized, in advance, by Anthem BCBS. Be sure to call **1-855-272-0696** at least 10 days prior to your scheduled procedure to see if prior authorization is required. See "Prior Authorization" for more information.

The plan covers surgical procedures performed on both an inpatient and outpatient basis, including but not limited to:

- Operative and cutting procedures.
- Endoscopic examinations, such as arthroscopy, bronchoscopy and laparoscopy.
- Other invasive procedures, such as angiogram, arteriogram, amniocentesis and tap or puncture of brain or spine.

When more than one surgical procedure is performed, the plan covers the charges for the primary procedure; the maximum allowed amount for each secondary procedure may be reduced.

In addition, the plan's coverage includes the services of a doctor who actively assists the operating surgeon when:

- The person receiving the surgery is confined as an inpatient in a hospital.
- The nature of the surgical procedure requires an assisting doctor.
- The assisting doctor is not paid by the hospital because he or she is a surgical resident or house staff doctor.

RECONSTRUCTIVE SURGERY

The plan covers reconstructive surgery when a physical impairment exists, and the primary purpose of the procedure is to correct conditions, functional problems or deformities that result from accidental injuries, traumatic scars, disease or congenital anomalies (such as cleft lip or cleft palate). Surgery necessary to correct deformities due to malignancy is also covered.

Reconstructive surgery for an accidental injury must be medically necessary and performed within 12 months of the date the accident occurred.

Surgery performed primarily for cosmetic or beautifying purposes, as determined by Anthem BCBS, is not covered.

RECONSTRUCTION FOLLOWING MASTECTOMY

The plan covers breast reconstruction following a medically necessary lumpectomy, partial mastectomy and full mastectomy on the same basis as other surgeries. This includes:

- Reconstruction of the breast on which the surgery has been performed.
- Surgery and reconstruction of the other breast for symmetry.

The plan also covers prostheses and treatment of physical complications during all stages of a mastectomy, including lymphedema.

SURGERY FOR MORBID OBESITY

IMPORTANT! All care, including travel and lodging, must be authorized, in advance, by Anthem BCBS. Call **1-855-272-0696** before you incur charges. See "Prior Authorization" for more information.

The plan covers certain surgical procedures for participants who have been diagnosed as morbidly obese — provided the care is authorized by Anthem BCBS in advance of your treatment. See "Prior Authorization" for more information.

Anthem BCBS has contracted with providers that specialize in the treatment of morbid obesity. The Blue Distinction Centers are facilities that have historically demonstrated their commitment to quality care for morbidly obese participants. Each center provides a full range of surgical services, including inpatient care, post-operative care, follow-up and patient education. For more information, call Anthem BCBS Customer Service at **1-855-272-0696**.

For purposes of plan benefits, surgical treatment of morbid obesity will be allowed only when all of the following conditions are met:

- The participant has been covered under the plan for at least 12 months prior to the surgery.
- The condition of morbid obesity has been documented for at least five years.
- The participant has completed growth (generally age 18 or older, or documentation of completion of bone growth).
- The participant has attempted weight loss without successful long-term weight reduction.
- The participant has participated in one of the following programs in order to prepare for surgery: (1) a doctor-supervised nutrition and exercise program, totaling six months or longer (with one of the programs being at least three months in duration) during the two-year period prior to surgery, and such program or programs have been documented in the participant's medical records; or (2) a doctor-supervised program (diet, exercise, and behavior modification) for at least three months prior to surgery.

Morbid obesity is defined as a condition in which persistent and uncontrollable weight gain causes a threat to life because the participant has:

- A body mass index (BMI) greater than 40, or
- A BMI greater than 35, and documented presence of coronary heart disease, Type 2 diabetes, clinically significant obstructive sleep apnea or hypertension.

Travel and Lodging

When prior authorization is received for surgery at a Blue Distinction Center that is more than 60 miles from your home, the plan can cover travel and lodging expenses only when approved, in advance, through Anthem BCBS. If you do not receive prior approval, the expenses will not be covered.

Travel and lodging can include:

- Transportation between home and the Blue Distinction Center, for evaluation or services.
- Lodging — up to $50 per person per night — for the patient who is being evaluated or receiving services, and one companion, when traveling with the patient (two companions if the patient is a minor child).

The plan covers up to $10,000 per surgery, in combined travel and lodging expenses for the patient and a companion or companions. The plan does not cover any costs associated with meals or convenience items.

GENDER AFFIRMING SURGERY

IMPORTANT! All gender affirming surgery must be authorized, in advance, by Anthem BCBS. Call **1-855-272-0696** in advance of receiving care. See "Prior Authorization" for more information.

The plan covers certain surgical procedures for participants who have been diagnosed with gender dysphoria — provided the care is authorized by Anthem BCBS in advance of your treatment. See "Prior Authorization" for more information.

Gender dysphoria is defined as the feeling of discomfort or distress that might occur in people whose gender identity differs from their gender assigned at birth or gender-related physical characteristics.

To learn more about what the plan covers, contact Anthem BCBS.

Organ and Bone Marrow/Stem Cell Transplants

IMPORTANT! All transplants must be authorized, in advance, by Anthem BCBS. Call **1-855-272-0696** as soon as you know that a transplant may be required. See "Prior Authorization" for more information.

The plan covers human organ and bone marrow/stem cell transplants when the procedure is authorized, in advance, by Anthem BCBS and performed at an in-network facility, including a Blue Distinction Center.

The plan also provides coverage for the evaluation, removal and transportation of the donor organ to the patient, but does not cover the costs associated with a donor search unless the search is made in connection with a transplant procedure arranged by the designated in-network facility.

The following transplants are covered only when performed at a Blue Distinction Center:

- Bone marrow (allogenic or autologous)
- Heart
- Heart/lung
- Kidney
- Liver/small bowel
- Kidney/pancreas
- Lung or double lung
- Liver
- Pancreas
- Small bowel

TRAVEL AND LODGING FOR TRANSPLANTS

When prior authorization is received for one of the transplants listed above and performed at a Blue Distinction Center that is more than 60 miles from your home, the plan may cover travel and lodging expenses only when approved, in advance, through Anthem BCBS. If you do not receive prior approval, the expenses will not be covered.

Travel and lodging can include:

- Transportation between home and the Blue Distinction Center for evaluation or services.
- Lodging — up to $50 per person per night — for the patient who is being evaluated or receiving services, and one companion, when traveling with the patient (two companions if the patient is a minor child).

The plan covers up to $10,000 per transplant, in combined travel and lodging expenses for the patient and a companion or companions. The plan does not cover any costs associated with meals or convenience items.

IMPORTANT! All travel and lodging must be authorized, in advance, through Anthem BCBS. The plan will only consider coverage for travel and lodging associated with the transplants listed above when performed at a Blue Distinction Center. See "Prior Authorization" for more information.

Well Child Care

When provided by an Anthem BCBS network provider and based on the Preventive Medicine Guidelines, the plan covers the full cost for certain preventive health services for participants under the age of 19. Preventive health services delivered by out-of-network providers are subject to the plan's coinsurance requirements.

To qualify, the services must comply with the Preventive Medicine Guidelines that comprise the Anthem BCBS Medical Policy. These Guidelines adopt the services recommended by several federal government and/or independent agencies responsible for the development and monitoring of preventive care. Many of the Guidelines take into account the child's gender, age and family medical history. For more information about what is covered, visit **www.anthem.com/preventive-care** and select the guideline that you want to view or call Anthem BCBS Customer Service at **1-855-272-0696**.

The types of services for children covered as preventive care services include but are not limited to:

- Well child care physical exams.
- Developmental assessments.
- Screening for depression and obesity.
- Obesity counseling.
- Routine childhood immunizations such as diphtheria; tetanus; pertussis; polio; chicken pox; measles, mumps, rubella; hepatitis A and B; pneumococcal; meningococcal; rotavirus; human papillomavirus; influenza; and COVID-19.

In addition, the plan covers the following screenings:

- Routine vision screening — but not exams — up to one screening every calendar year, limited to:
  - Visual acuity tests.
  - Color blindness tests.
  - Cover testing to test for proper eye coordination.
  - Slit-lamp examination to examine the health of the eyes.
  - Pupil dilation to view the eye's internal structures.
  - Glaucoma testing.
  - Visual field testing for peripheral vision.

  The plan does not cover refractions, retinoscopy, autorefractors/aberrometers, fitting of contact lenses and laser retina scans as part of any vision screening.
- Routine hearing screening — but not exams — up to one screening every calendar year.

Miscellaneous

The plan covers the following:

- The administration of injections by a doctor (unless they are otherwise excluded under the plan).
- Oxygen, and its administration.
- Casts, splints and trusses.
- Blood, blood plasma and its administration.

Prescription Drug Coverage

IMPORTANT! All HealthPlus PPO options only cover prescriptions filled at a CVS Caremark network pharmacy. Prescriptions filled at pharmacies that are not in the CVS Caremark network are not covered.

Additionally, some medications require prior authorization before they are covered by the plan.

For more information or to find a CVS Caremark network pharmacy, call **1-800-774-5780** before you fill your prescription.

Prescription drug benefits are managed by CVS Caremark. To get the most from your plan benefits:

- **Your prescription must be filled at a local CVS Caremark network pharmacy** (including a CVS Pharmacy store), the CVS Caremark Mail Service Pharmacy or the CVS Specialty Pharmacy.
- **Fill your prescription with a generic alternative** — when available. If you choose to fill your prescription with a brand-name drug (even when your doctor writes "dispense as written"), you will be responsible for the difference in cost, in addition to the higher copay.
- **Use the CVS Caremark Maintenance Choice program** to fill your ongoing long term medications (other than controlled substances and specialty medications). The Maintenance Choice program gives you the option of filling up to a 90-day supply at the CVS Caremark Mail Service Pharmacy or your local CVS Pharmacy store.

  If you use a local network pharmacy (other than a CVS Pharmacy store) for other than the original prescription and one 30-day refill for long-term maintenance medications, you will have to pay the full cost of the prescription and you will not be reimbursed.
- **Use the CVS Specialty Pharmacy** to fill your "specialty" medications. The plan only covers the cost of the original prescription at a local CVS Caremark network pharmacy.

- **Use a preferred brand-name drug** from the CVS Caremark Performance Drug List whenever a generic is not available.
- **Obtain prior authorization**, when needed. Certain medications require approval from CVS Caremark before the drug is dispensed.
- **Complete certain ActionCards through GPI FIT (www.gpifit.com) each year** if you have been diagnosed with asthma, diabetes, chronic obstructive pulmonary disease, congestive heart failure, coronary heart disease, hypertension or high cholesterol. Once you complete the required ActionCards, your copay for ongoing generic medications for your condition, when filled through the Maintenance Choice program, will be waived for the rest of the calendar year.

If you have questions about your coverage or how to locate a pharmacy, call CVS Caremark Customer Care at **1-800-774-5780**.

Refer to the "Schedule of Benefits" for specifics on how much you pay for covered medications.

Note: Prescription drugs administered while confined to a hospital or other inpatient facility, in your doctor's office, as part of a home health care treatment, or during chemotherapy generally are covered under the medical provisions of the plan administered by Anthem BCBS.

RETAIL PHARMACIES

To fill your short-term prescriptions (up to a 30-day supply) at a local CVS Caremark retail network pharmacy:

- Find a network pharmacy by visiting **www.caremark.com**.
- Present your card to the pharmacist with your prescription. If you need to transfer a prescription, bring your prescription bottle or label to the pharmacy.
- When you pick up your prescription, pay the pharmacist for your share of the cost. If you forget your card, let the pharmacy know that you have coverage through the CVS Caremark network. The pharmacy may be able to verify your coverage if you provide them with your Social Security number.

MAIL SERVICE OR CVS PHARMACY STORE

IMPORTANT! Other than the initial prescription and one refill, long term medications must be filled through the CVS Caremark Mail Service Pharmacy or at a local CVS Pharmacy store.

For more information, call **1-800-774-5780** before you fill your prescription.

When you start a new long term medication, your doctor should write two prescriptions: one for a short-term supply to be filled immediately and the other for up to a 90-day supply (plus refills).

Through CVS Caremark's **"Maintenance Choice"** program, you have two choices for filling your long term medication:

- Through the CVS Caremark Mail Service Pharmacy, where your prescription will be mailed directly to your home, generally within 14 days, or
- At your local CVS Pharmacy store, where you can pick up your prescription in person.

CVS Caremark Mail Service Pharmacy

The CVS Caremark Mail Service Pharmacy provides you with the convenience of home delivery with the availability of a Mail Service pharmacist by phone. To get started:

- Make sure your prescription is for up to a 90-day supply, plus refills.
- Call **1-866-776-5677** for FastStart service. Provide the pharmacy representative with the requested information, and the representative will contact your doctor directly to get your prescription. Be sure to have your credit card information to cover your share of the cost.
- Alternatively, complete and return a *Mail Service Order Form* and *Patient Profile Form* to CVS Caremark, along with your original prescription and a check or credit card number for your share of the cost (call CVS Caremark Customer Care at **1-800-774-5780** for this information).

To allow time for filling and mailing your prescription, refills should be ordered at least 14 days before your current prescription runs out.

Although most prescriptions taken on a regular basis can be ordered through the CVS Caremark Mail Service Pharmacy, some may not be available due to state and federal regulations. This includes, but is not limited to, controlled substances (such as certain pain medications).

Local CVS Pharmacy Store

If you want to pick up your maintenance medication, you can have your long term prescription filled at a local CVS Pharmacy store.

- First, make sure your prescription is written for up to a 90-day supply, plus refills.
- Take your original prescription to your local CVS Pharmacy store. Be sure to let the pharmacist know that you are selecting the "Maintenance Choice" option.
- When your prescription is ready, you will pay the same amount for your prescription as you would through the Mail Service Pharmacy.

If you want to change an existing maintenance prescription from the CVS Caremark Mail Service Pharmacy, call CVS Caremark Customer Care at **1-800-774-5780** to let them know. They can help you transfer refills to the local CVS Pharmacy store of your choice.

CVS SPECIALTY PHARMACY

IMPORTANT! Other than the initial prescription, specialty medications must be filled through the CVS Specialty Pharmacy.

In addition, some specialty medications require prior authorization before they are covered by the plan.

For more information, call the CVS Specialty Pharmacy at **1-800-237-2767** before you fill your prescription.

Certain complex chronic and/or genetic conditions are treated with special pharmacy drugs, often in the form of injected or infused medicines. Many of these drugs require special handling. The CVS Specialty Pharmacy provides these medications directly to you, along with any supplies, equipment or care coordination needed.

Specialty medications are often used for treatment of conditions such as asthma, cancer, cystic fibrosis, hepatitis C, certain immune disorders, multiple sclerosis, rheumatoid arthritis and transplants.

Other than the initial prescription, specialty medications must be filled through the CVS Specialty Pharmacy. Your medication can be delivered, confidentially, to the location of your choice (home, doctor's office or vacation destination). In addition, you have the option of having your medicine delivered directly to your local CVS Pharmacy store for pick up (for example, if your medication must be refrigerated and you will not be home at the time it would be delivered).

For a current listing of medications on the CVS Specialty Pharmacy Drug Listing, visit **www.cvsspecialty.com**.

Remember, this listing changes from time to time. To reach the CVS Specialty Pharmacy, call **1-800-237-2767**.

COVERED PRESCRIPTION DRUGS

The plan covers prescription drugs that are medically necessary and clinically appropriate. Remember — certain medications require prior authorization before the drug is dispensed.

Eligible prescription drugs include those that:

- Are approved by the FDA, provided they are not considered experimental or investigational.
- Are prohibited by federal or state law from being dispensed without a prescription.
- Are filled at a local CVS Caremark network pharmacy (including a CVS pharmacy store), the CVS Caremark Mail Service Pharmacy or the CVS Specialty Pharmacy.
- Are a compound medication of which at least one ingredient is a legend drug.
- Are dispensed in accordance with the written prescription of your attending doctor.
- Meet CVS Caremark's criteria for clinical efficacy (with respect to both the type and brand of medication).

In addition, the following drugs are covered when prescribed in writing by a doctor:

- Injectable insulin, insulin syringes, diabetic test strips, lancets, insulin pumps, glucometers and tubing for participants who are insulin-dependent.
- Oral contraceptives.
- Non-oral contraceptives, limited to Nuvaring, Ortho Evra and diaphragms (other forms of non-oral contraceptives may be covered under the medical provisions of the plan. See "Care in a Health Care Provider's Office" and "Miscellaneous" for more information).
- Prescription prenatal vitamins.
- Zanamivir (also marketed under the trade name Relenza) — when purchased through a local retail pharmacy.
- Medications for the treatment of acute migraine headache attacks — subject to dispensing limits (if additional medication is needed beyond the dispensing limits imposed by the plan, your doctor may call CVS Caremark to see if additional amounts may be considered; see "Prior Authorization of Prescription Drugs").
- Injections prescribed by a doctor, including self-administered injectables, provided they are not otherwise excluded under another provision of this plan.
- Over-the-counter medications as required by federal law (see "Preventive Medications" for more information).

Ostomy and colostomy supplies and apparatus and surgical stockings (when medically necessary) may be covered under the plan as disposable medical supplies. See "Durable Medical Equipment and Disposable Supplies" for more information.

Preventive Medications

Federal law requires that certain "preventive" medications be covered in full with no copay — when filled at an in-network pharmacy. Preventive medications can include certain over-the-counter medications with no copay — as long as you have a doctor's written prescription.

For a full list of what is considered preventive and covered by the plan, visit **www.caremark.com** or call CVS Caremark Customer Care at **1-800-774-5780**.

PRESCRIPTION DRUG EXCLUSIONS

The plan does not pay for any of the following, even if prescribed by a doctor or medically necessary:

- Prescription medications filled at a pharmacy other than a local CVS Caremark network pharmacy (including a CVS pharmacy store), the CVS Caremark Mail Service Pharmacy or the CVS Specialty Pharmacy.
- Prescription maintenance medications filled at a pharmacy other than the CVS Caremark Mail Service Pharmacy or a local CVS Pharmacy store after the original prescription and one 30-day refill.
- Specialty medications filled at a pharmacy other than the CVS Specialty Pharmacy after the initial prescription fill.
- Prescription medications that require a prior authorization from CVS Caremark — when the prior authorization has not been requested and/or approved.
- Non-legend drugs, except as noted within this section.
- Over-the-counter drugs or supplies, including vitamins and minerals, except as noted within this section.
- Immunization agents.
- Blood and blood plasma (covered as a medical benefit).
- Nutritional supplements, dietary supplements, meal replacements, infant formula or formula food products.
- Antacids.
- Prescription drugs used solely for the purpose of weight control and/or reduction.
- Medications in connection with withdrawal from caffeine or other addictive behaviors.
- Products to treat hair loss, thinning hair, unwanted hair growth or hair removal.
- Drugs that are considered cosmetic agents or used solely for cosmetic purposes, such as anti-wrinkle medications.
- Zanamivir (also marketed under the trade name Relenza) — when purchased through the CVS Caremark Mail Service Pharmacy.
- Infertility medications.
- Medications taken or administered while confined to a hospital or other inpatient facility, in your doctor's office, as part of a home health care treatment, or during chemotherapy (these may be covered under the medical provisions of the plan).

- Any prescription medication that does not meet the requirements for clinical efficacy, as determined by CVS Caremark, and for which therapeutic alternatives are available.
- Medications that are experimental or investigational, not approved by the FDA or that are not approved for the diagnosis for which they have been prescribed, or not approved for the method of administration, unless otherwise approved by CVS Caremark based on clinical criteria.
- Drugs whose intended use is illegal, unethical, imprudent, abusive or otherwise improper.
- Replacement of lost or stolen medications.
- Prescriptions that exceed a reasonable quantity as determined by CVS Caremark.
- Prescriptions dispensed:
  - For controlled substances, more than six months after the date of the original prescription.
  - For all other medications, more than one year from the original date of the prescription.
- Prescriptions that are prohibited by applicable law or regulations.
- Prescriptions filled by a pharmacy outside the United States.
- Drugs used to enhance athletic performance.
- Medications covered by any government program, including Workers' Compensation, occupational disease or other similar legislation, whether or not in force.
- Prescriptions filled after your coverage ends.

There are other prescription drugs and supplies not covered. If you have questions about a specific prescription drug, contact CVS Caremark Customer Care at **1-800-774-5780**.

Employee Assistance Plan

In addition to the benefits provided by this plan, you are eligible to use the services of the Company's employee assistance plan (EAP) through Magellan Healthcare. The EAP is available to you and your family members even if you are not enrolled in a Company medical plan.

How the EAP Works

Through the EAP, you and your family members have access to a range of resources and services to help you manage emotional, mental and relational aspects of your life, including stress, personal conflicts, financial concerns and legal issues.

You can reach the EAP 24 hours per day, 7 days a week, at **1-800-327-9781**. When needed, the EAP will schedule an appointment with a Magellan network professional in your area. If you or a family member needs counseling beyond what is available through the EAP, Magellan may be able to help transition your care to a network provider in your medical plan.

Available Services

The EAP provides you with confidential access to the following — all at no cost to you:

- Counseling — up to 8 sessions per issue each year. Access a nationwide network of licensed counselors for support stress, anxiety, grief, substance misuse, relationships, parenting and more. Sessions are completely confidential and available in-person, by text message, live chat, phone or video call.
- Crisis management with a licensed clinician. Access immediate, phone-based crisis intervention and stabilization services with a clinician 24 hours a day, 7 days a week.
- Lifestyle coaching — up to 6 individual sessions per goal per year. Life coaches can meet with you by phone or video and help you with define and reach your goals for personal improvement, healthy eating, weight loss and more.
- Assistance with financial wellness, legal services and identity theft resolution. Meet with experts that can help you take control of your finances, resolve legal issues (such as estate planning and family law) and restore credit when you have been the victim of identity theft.
- Digital emotional wellbeing program. Access the online program and download apps to help improve your overall health and wellbeing. Complete activities to earn points, see your progress and sync to other trackers.
- LifeMart® discount center. LifeMart offers hundreds of deals on nationally recognized brand-name products and services, such as consumer goods, travel, child and elder care, fitness centers and movie tickets.

Visit the Magellan website (**www.magellanascend.com**) to find providers and learn more about the services. In addition, the online Learning Center offers access to health and wellness information, self-assessments, webinars, podcasts and state-specific legal forms.

Tobacco Cessation Program

You and your spouse are eligible to participate in the Company's tobacco cessation program, Clickotine, offered through Magellan Healthcare. The program is available regardless of whether you are enrolled in a Company medical plan.

How the Program Works

The Clickotine program uses clinically-driven app technology to help you create and stick to a quit plan and overcome nicotine cravings.

The Clickotine app includes these key features:

- Personalized quit plan and messaging that keeps you on track toward your quit goal.
- Coaching with licensed tobacco cessation coaches through text messages.
- Targeted strategies, such as reduced craving episodes through controlled, mindful breathing.
- Real-time social support and encouragement from friends, family and community that increases your odds of success.
- Digital diversions, such as games and activities, to help divert cravings to healthier actions.
- Health outcome improvement monitoring, allowing you to track improvements in certain health statistics, such as pulse rate, oxygen level and body temperature.
- Financial reward tracking to show you how much you have saved by quitting.

GETTING STARTED

On your smart phone or device, download the Clickotine mobile app from Google Play or the Apple App Store.

- In the app, select "Sign Up" to create your account.
- Enter the Client ID code for GPI (0A6C34).
- Answer a few questions and complete the assessment to customize your plan.

When you are done, you are ready to start using the program.

If you need help accessing the app, call **1-800-327-9781**.

NICOTINE REPLACEMENT THERAPY

In addition to the app, the program offers additional help through distribution of over-the-counter medications (such as nicotine gum, nicotine patches or nicotine lozenges). These medications are:

- Provided at no cost to you.
- Mailed directly to your home.
- Offered for up to 26 weeks a year.

The type of nicotine replacement product and how long it is available are based on your specific situation. Find more information on the mobile app or by messaging your quit coach.

Prescription Drug Benefits

If you need additional help, certain prescription and over-the-counter medications may be covered if you:

- Are enrolled in a Company HealthPlus PPO plan.
- Have a prescription for your medication.

For more information about covered prescriptions, call CVS Caremark Customer Care at **1-800-774-5780**.

Exclusions and Limitations

The program does not cover:

- Nicotine replacement medications not approved by the program.
- Other forms of treatment for tobacco cessation, such as acupuncture and hypnosis.
- Nicotine replacement products for more than 26 weeks a year.

What is Not Covered Under the Plan

The following are general limitations and exclusions for which no benefits are payable under the plan.

- Charges for covered expenses incurred by you or your family members prior to the date that you or your family members become covered under this plan.
- Charges in excess of the maximum allowed amount or in excess of the frequency allowed for such services, as determined by Anthem BCBS or CVS Caremark (as applicable).
- Charges for services and medications for which a prior authorization is required, and such prior authorization is not received.
- Charges for any service, supply or prescription drug that is not medically necessary for the treatment of the patient's condition, as determined by Anthem BCBS or CVS Caremark (as applicable), unless specifically stated as a covered expense.
- Charges in connection with any treatment, service or prescription drug not prescribed by an eligible health care provider.
- Facility charges made by a health care facility, including a doctor's office, when the facility is not licensed to provide these services in accordance with the laws of the state in which the facility is located.
- Charges for accrued interest on a claim.
- Charges for completion of claim forms, whether or not in connection with a prior authorization review.
- Charges for furnishing medical records or reports.
- Charges for failure to keep a scheduled visit with a doctor or other health care provider.
- Charges for services furnished by an immediate relative (spouse or domestic partner (whether or not legally recognized), parent, child, sibling, in-law, grandparent and grandchild — by blood, marriage or adoption) or a member of your household (anyone living in your home, including your children who are regularly attending school on a full-time basis).
- Charges in connection with an office visit for injection of a medication not covered by the plan, or for which prior authorization is required, but not received.
- Charges in connection with a hospitalization for a surgical procedure for which no benefits are payable.
- Charges associated with complications from procedures that are not covered under this plan.
- Charges for a hospital stay that is primarily for diagnostic studies and/or physical therapy — unless medically necessary.
- Charges for travel to and from a health care provider's office or hospital, and any other travel, whether or not prescribed by a doctor, unless specifically covered under this plan.
- Charges for care received in an emergency facility, when the condition does not qualify as a medical emergency, as defined by this plan.
- Charges for or in connection with any service, device, procedure, treatment method or supply that is determined to be experimental or investigational by the appropriate claims administrator in accordance with its written clinical guidelines, regardless of whether such service, device, procedure, treatment method or supply has been approved by the FDA, American Medical Association, other national medical society, dental society or other regulatory agency. A copy of the written clinical guidelines can be obtained at any time by contacting Anthem BCBS Customer Service or CVS Caremark Customer Care, as applicable.

  However, routine costs (as defined under federal law) for services and supplies provided in connection with participation in an approved clinical trial for cancer or other life-threatening disease may be considered under limited circumstances. Contact Anthem BCBS Customer Service or CVS Caremark Customer Care, as appropriate, for more information.
- Charges for treatment, therapy, supplies or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.

- Charges for religious, marital or sex counseling, including services and treatment related to religious counseling, marital/relationship counseling and sex therapy, unless specifically covered under this plan.
- Charges for the following physical or psychological examinations — unless covered as part of a preventive health care exam (see "Preventive Care for Adults" and "Well Child Care"):
  - Examinations solely required by an insurance company to obtain insurance.
  - Examinations solely required by a governmental agency, such as the Federal Aviation Administration or the Department of Transportation.
  - Examinations solely required by an employer in order to begin or continue working.
  - Examinations required for foreign travel.
  - Examinations required for participation in school athletic programs, recreational camps or retreats.
  - Examinations required for marriage or adoption.
  - Examinations related to judicial or administrative proceedings or orders.
- Charges for immunizations required for travel, unless specifically covered under this plan.
- Charges for preventive medicines, digestive aids, minerals or other dietary supplements, whether or not prescribed by a doctor, unless specifically covered under this plan.
- Charges for more than one item of equipment for the same or similar purpose.
- Charges for or in connection with custodial or sanitarium care, such as a place for rest or recuperation (for example, a spa resort).
- Charges associated with a stay in a rest home, home for the aged, a nursing home or a similar facility.
- Charges for education or training of a patient regarding nutrition, unless specifically covered under this plan.
- Charges for education or training on how to administer medications or any other medical care-related instruction.
- Charges for services, treatment, educational testing or training related specifically to learning disabilities (except for the initial visit to diagnose the condition).
- Charges for care in a Christian Science Sanitarium, unless the confinement is for an illness or injury which would otherwise require hospitalization.
- Charges in connection with acupuncture, unless provided by a doctor as a form of anesthesia in connection with a surgery that is covered under the plan.
- Charges in connection with hypnosis, biofeedback, recreational or education sleep therapy, or other forms of self-care or self-help training.
- Charges for or related to the following types of treatment: primal therapy, rolfing, chelation therapy, vestibular rehabilitation, psychodrama, megavitamin therapy, bioenergetic therapy, electromagnetic therapy, vision perception training, salabration or carbon dioxide therapy.
- Charges related to athletic performance or lifestyle enhancement.
- Charges for amniocentesis, ultrasound or any other procedures requested solely for gender determination of a fetus, unless medically necessary to determine the existence of a gender-linked genetic disorder.
- Charges for childbirth classes.
- Charges in connection with reversal of sterilization procedures.
- Charges in connection with infertility treatment procedures, including, but not limited to:
  - Artificial insemination.
  - Purchase of donor sperm and any charges for the storage of sperm.
  - Purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers.
  - Cryopreservation and storage of cryopreserved embryos.
  - Home ovulation kits.
  - In-vitro fertilization, gamete intrafallopian tube transfer (GIFT), zygote intrafallopian tube transfer (ZIFT) and intracytoplasmic sperm injection, or any other forms of infertility treatments, including all related charges.
  - Frozen embryo transfers, including thawing.
- Charges for fetal tissue transplantation.
- Charges associated with surrogate mothers who are not participants in this plan.

- Charges in connection with adoption.
- Charges for abortion, except when medically necessary.
- Any treatment or services in connection with the prevention of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids, or any other care, repair, removal, replacement or treatment of the teeth or surrounding tissues (including dental implants), except for the following:
  - Medically necessary treatment to repair sound natural teeth that are injured as a result — of an accidental injury, when services are delivered within 12 months following the accident.
  - Excision of a tumor or cyst, or incision and drainage of an abscess or cyst.
  - Treatment of cleft lip and cleft palate.
  - Any oral surgical procedure not involving any tooth structure, alveolar process or gingival tissues.
- Charges for removal of impacted teeth, including wisdom teeth.
- Charges incurred in connection with treatment of temporomandibular joint (TMJ) disorders and associated conditions.
- Charges for or in connection with speech therapy for:
  - A child whose speech was suppressed due to developmental delays or because of an illness or injury before the child developed any functional speech.
  - Modulation.
  - Articulation.
  - Stuttering.
  - Stammering.
  - Elimination of a lisp.

  This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function as the result of illness or injury, or a person who has been diagnosed with autism.
- Charges for special education, including lessons in sign language to instruct a participant whose ability to speak has been lost or impaired.
- Charges for orthoptics, communication aids, eyeglasses or lenses of any type (except for loss of a natural lens or initial contact lenses prescribed immediately following cataract surgery) or examinations for prescription or fitting of these devices.
- Charges for eye refractions, retinoscopy, autorefractors/ aberrometers, fitting of contact lenses and laser retina scans.
- Charges in connection with eye surgery, such as radial keratotomy and refractive surgery, when the primary purpose is to correct myopia, hyperopia or astigmatism.
- Charges in connection with cosmetic surgery. However, surgery for the following may be covered by the plan, subject to prior authorization approval through Anthem BCBS:
  - Reconstructive surgery for a person who has suffered an accidental injury, and such injury results in bodily damage requiring the surgery, when the surgery is performed within 12 months following the accident, and both the surgery and the reconstructive surgery are medically necessary.
  - Reconstructive surgery following a medically necessary lumpectomy or mastectomy, including reconstruction of the breast on which the procedure was performed, as well as surgery and reconstruction of the other breast for symmetry.
  - Surgery that is medically necessary to correct a congenital anomaly in a child (such as cleft lip or cleft palate).
- Charges for weight loss treatment, surgery or commercial weight loss programs incurred in connection with any form of obesity, including but not limited to fees, dues, nutritional supplements, food, vitamins, prescriptions and exercise therapy, except as specifically covered under this plan for morbid obesity (see “Surgery for Morbid Obesity” for more information).
- Charges for inpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education.

- Charges for personal comfort items, including services and supplies that are not directly related to medical care, such as guest meals and accommodations, personal care kits, radio and television rentals, telephone rentals, homemaker services, travel expenses, take-home supplies and other similar items and services.
- Charges in connection with withdrawal from caffeine or other addictive behaviors, unless specifically covered under this plan.
- Charges in connection with alopecia (loss of hair), including hair growth products — except under very limited circumstances.
- Charges for equipment and items for the following uses:
  - Hygiene or self-help including, but not limited to, bathtub chairs, stair gliders or elevators, safety wrap bars or saunas.
  - Environmental control including, but not limited to, air purifiers, humidifiers and electrostatic machines.
  - Allergy control including, but not limited to, hypo-allergenic pillows, mattresses or waterbeds.
  - Institutional care including, but not limited to, fluidized beds and diathermy machines.
  - Non-therapeutic supplies including, but not limited to, auto-tilt chairs, whirlpool baths and modifications to living quarters (such as handrails, ramps, stair glides) or vehicles.
  - Exercise or training including, but not limited to, exercise cycles, treadmills, swimming pools, exercise and massage equipment.
  - Convenience including but not limited to blood pressure monitoring devices.
- Charges for non-standard allergy testing and/or treatment, including, but not limited to, skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific Candida sensitivity and urine auto injections.
- Charges for consumable medical supplies and scalp hair prostheses (wigs, toupees, hairpieces), unless specifically covered under this plan.
- Charges for routine hand or foot care, including reduction of nails, calluses and corns, flat feet, fallen arches, weak feet, chronic foot strain or asymptomatic complaints related to the feet.
- Charges for or related to shoe inserts, arch supports, orthopedic shoes and foot orthotics, except the plan will consider the following:
  - Orthopedic shoes that are an integral part of a leg brace and the cost for the shoe is as part of the cost of the brace.
  - Medically necessary therapeutic shoes furnished to diabetic members.
  - Rehabilitative foot orthotics that are prescribed as part of post-surgical or post-traumatic casting care.
  - Prosthetic shoes when all or a part of the foot has been amputated.
- Charges for private duty nursing, unless part of a program offered through an approved hospice care program or home health care agency.
- Charges and supplies in connection with an organ, tissue or bone transplant when related to animal organ transplants, animal tissue transplants, artificial organ transplants (except for porcine heart valves) and mechanical organ transplants.
- Charges for transplant donor search fees unless specifically covered under this plan.
- Charges for donor costs for organ or tissue transplant to another person.
- Charges for a health care provider who has not yet completed medical training or is not yet licensed under the applicable state licensing law in which he or she is practicing.
- Charges for hospital services of doctors, surgeons or technicians who are employed by the hospital (such as resident doctors and interns), when the provider bills the plan separately.
- Charges for accidental bodily injury or illness caused by war, declared or undeclared, or by an act of war, by reason of past or present service in the military, naval, or air forces of any country or any civilian non-combat unit serving with such forces, unless otherwise required under federal law.
- Charges you are not legally obligated to pay, including amounts in excess of discount rates separately negotiated between the Company, Anthem BCBS or CVS Caremark and any health care provider.

- Charges for care made by a hospital owned or run by the United States Government, except charges for care or treatment of non-service related illness or injury shall be covered as any other expense.
- Charges in connection with medical services provided by the Company.
- Charges for which you are entitled to payment or reimbursement, in whole or in part, by or through any local, state or federal program, when that program has primary payment responsibility.
- Charges or services for government programs available to you as a member of the community, such as school speech and reading programs.
- Charges resulting from participation in or attempts to commit an assault, battery or felony.
- Charges for services that have been court-ordered (including services required as a condition of parole or probation) or are custodial or solely for the purpose of environmental control, such as a halfway house, school or domiciliary institution, when associated with a diagnosis of acute stress reaction, childhood or adolescent adjustment reaction and similar related social, cultural or work situations.
- Charges that would not have been made if coverage under this plan had not existed.
- Charges that are eligible, paid or payable (without regard to fault) under any medical payments provision, no-fault automobile insurance, personal injury protection or other coverage (e.g., homeowners insurance, boat owners insurance, personal liability insurance, etc.), or excess insurance policy (e.g., school and/or athletic policies), including charges for services that are applied toward any deductible, copay or coinsurance of such policy, and regardless of whether you are covered by said policy when required by law.
- Charges to the extent that payment is unlawful where you reside when the expenses are incurred.
- Charges for an illness or injury arising out of employment for wage or profit for which someone is or may be eligible for benefits under Workers' Compensation, occupational disease or other similar legislation, whether or not in force.
- Charges for services rendered or supplies obtained after the date the coverage has terminated.
- Charges for any claim when the documentation of the claim has been falsified.
- Charges eligible for reimbursement under any other group health plan, when that plan has primary payment responsibility. See "Coordination of Benefits With Other Plans" for more information.
- Charges eligible for reimbursement under any prior group health plan covering the participant, when that plan has primary payment responsibility under any extended benefits provisions. See "Coordination of Benefits With Other Plans" for more information.
- Any other charges or services not specifically listed as a covered expense.

For information about specific coverage, call the appropriate claims administrator.

Claiming Benefits

Claim filing requirements differ by the type of service you receive, who delivers your care and whether the provider is in-network or out-of-network.

See "Appealing Denied Claims" for important information about applicable deadlines for filing an appeal or lawsuit for denied benefits.

IMPORTANT! Due to the hardship caused by the COVID-19 pandemic, you may be eligible for extra time to file your benefit claims and appeals. Specifically, the period beginning March 1, 2020, and ending 60 days after the federal government announces the end of the COVID-19 national emergency period may not count for purposes of determining whether you have met the filing deadlines shown below. For more information, contact Anthem BCBS.

Filing a Medical Claim

The filing of a claim for benefits depends on whether you go to an Anthem BCBS network provider or a provider outside the network.

- If you receive care from a provider who is part of your **Anthem BCBS network**, you do not need to file your claim. The provider will file the claim on your behalf. However, you are responsible for following up to ensure that the claim is filed within the proper time frame.

  The plan will pay its share of covered expenses directly to your Anthem BCBS network provider. You will be responsible for paying the provider for your share of covered expenses, such as your deductible, coinsurance and costs that are not covered by the plan.

- If you go to an **out-of-network provider or have primary coverage through another health care plan**, generally you are responsible for submitting a claim for benefits. In most cases, the plan will make payment directly to you for any services covered by the plan and you will be responsible for paying the provider for the services you received.

To submit a claim for benefits, complete and return a medical claim form (available on **www.anthem.com**), along with an itemized original bill from your provider that includes:

- The employee's name.
- Patient name and date of birth.
- Date(s) of service.
- Diagnosis code(s), including a description of the diagnosis.
- Medical procedure(s) codes, including a description of the services rendered.
- Charge for each service.
- Provider's name, address, phone number and tax identification number.

Claims for each family member should be submitted separately.

Claims should be filed and returned as soon as possible after services have been received to:

Anthem Blue Cross Blue Shield
P.O. Box 105187
Atlanta, GA 30348-5187

Be sure to keep copies of your completed claim form and itemized bill.

Alternatively, your provider can file claims for you by mailing an itemized bill, along with a completed claim form, to the above address, or by filing the claim electronically through a medical claims clearinghouse.

If you have any questions about submitting a claim or the status of a claim, contact Anthem BCBS Customer Service at **1-855-272-0696** Monday through Friday between the hours of 8 a.m. and 8 p.m., Eastern Time. You also can view the status of your claims by logging on **to www.anthem.com** (registration required).

IMPORTANT! Claims filed more than 12 months after the date of service will not be considered unless you can show that you submitted the claim as soon as possible.

IF YOU ARE COVERED BY MORE THAN ONE PLAN

If another plan is responsible for paying benefits before this plan, submit your claim to that plan first. After you receive your benefit payment, submit your claim to Anthem BCBS, along with a claim form, a copy of the itemized bill and the other plan's "explanation of benefits" statement. Be sure to keep a copy of your completed claim form and any attachments for your records.

See "Coordination of Benefits With Other Plans" for more information on which plan pays first when you have coverage through two plans.

IMPORTANT! You can appoint an authorized representative to act on your behalf and receive notices in connection with your claim or claims. To designate an authorized representative, you must return a completed authorized representative form, available from the appropriate claims administrator, that identifies the individual or entity involved, the extent to which they will be acting on your behalf and the time period or claim to which the authorization applies.

DECISION ON YOUR INITIAL CLAIM

Anthem BCBS will review your claim and notify you of the decision within a reasonable time period, but not later than the time periods required by law.

Anthem BCBS will notify you of the decision on your claim as follows:

- **Prior authorization claim reviews**[1]
  - **If your condition is urgent**, you will be notified verbally of the decision as soon as possible — but not later than 72 hours after your request is received. Any verbal decisions will be followed by a written notification within three calendar days. If additional information is needed to make a decision, you will be notified within 24 hours. Anthem BCBS or CVS Caremark, as applicable, will notify you of its final decision within 48 hours after all the information has been received. If your prior authorization is denied, the notice will also include a description of the expedited review process.

    For purposes of this plan, "urgent" means that a quick decision is needed because any delay could jeopardize your life or health, your ability to regain maximum function or, in the opinion of a doctor with knowledge of your medical condition, subject you to severe pain that cannot be managed without the care or treatment.

1 *Refer to "Prior Authorization" for more information.*

– **If your condition is not urgent**, you will be notified of the decision within 15 calendar days after receiving your request. You will be notified if:

  - A 15-day extension is needed because special circumstances apply, or
  - You or your doctor has not provided all the information needed to make a decision. You will have up to 45 days to provide the information.

– **If you received prior authorization for a course of treatment,** and:

  - You requested an increase in the number of treatments or the period of time for treatment, you will be notified of the decision on your request based on whether your condition is urgent (as defined above) or non-urgent, or
  - The claims administrator has determined that coverage for services or supplies for which you already received prior authorization should be reduced or ended early, you will be notified sufficiently in advance of the change to allow you to appeal the decision before your coverage ends.

- **All other claim reviews**

  – If you have already received care, you will be notified of the plan's decision within 30 calendar days after receipt of your claim. You will be notified if:

    - A 15-day extension is needed because special circumstances apply, or
    - You or your doctor has not provided all the information needed to make a decision. You will have up to 45 days to provide the information.

A benefit summary, called an explanation of benefits statement, will be sent to you when your claim has been processed. This will explain what service was performed, how much the provider charged, how much is covered by the plan, how your benefit payment was calculated and to whom payment was made. If you received care from an Anthem BCBS network provider, payment (if any) will be made directly to the provider. If you see any out-of-network provider, payment (if any) will be made to you and included with your explanation of benefits statement. Regardless of whether payment is made to your provider or you, you are responsible for any deductible, out-of-pocket expenses and charges not covered by the plan.

If your claim is totally or partially denied or reduced, the notice will include the following:

- Information to identify the claim involved, including the date(s) of service, the provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meaning.
- The specific reason for the denial.
- The specific reference to the plan provisions on which the denial is based.
- A description of any additional material or information required by the plan to reconsider the claim and an explanation of why such material or information is necessary.
- Information about whether a rule, guideline, protocol or other criterion was relied upon in reviewing your claim or a statement that such was relied upon and will be provided to you, free of charge, upon request.
- For claims involving medical necessity, experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment used in reviewing your claim or a statement that such explanation will be provided to you, free of charge, upon request.

- A description of the plan's internal and independent, external review processes, including:
  - Information on how to initiate an appeal.
  - The time limits under which you can file an appeal.
  - How and when an expedited review can be requested for certain types of claims (for example, urgent claims).
- The availability of and contact information for any office of health insurance consumer assistance or ombudsman who may assist you with your appeals and review processes.
- A statement of your right to bring civil action under ERISA if you appeal and the claim denial is upheld.

Filing an HRA Claim

IMPORTANT! Save your itemized bills (listing the provider's name, date, amount and item purchased) and any documentation that confirms you received eligible services or products. Saving receipts helps you keep track of your expenses. Plus, documentation may be required to validate your claim.

You have two options for claiming reimbursement from your HRA for out-of-pocket expenses associated with medical, prescription drug, dental and vision[1]. You can:

- Use your HealthEquity debit card.
- Request reimbursement from HealthEquity online or by mail or fax.

HEALTHEQUITY DEBIT CARD

If you enroll in a HealthPlus PPO medical plan, you will receive a HealthEquity debit card. Your card can be used to pay for eligible out-of-pocket **medical, prescription drug, dental and vision expenses** directly from any available balance in your HRA[1].

The initial dollar limit on your debit card will be based on the balance in your HRA on January 1 — plus the annual amount you elected to contribute (if any) to your health care spending account. If you are enrolled in the health care spending account also, claims will be paid from your HRA first.

The balance on your card will change throughout the year:

- When claims are paid from your account, including when you use your debit card for eligible expenses.
- After Healthy Rewards are earned and added to your HRA.
- If you change your health care spending account election during the year.

By using your HealthEquity debit card, you acknowledge that you will only use the card for expenses for yourself and your eligible dependents that have not already been reimbursed or will be filed for reimbursement under any other plan.

1 Only out-of-pocket expenses from a GPI medical, dental and vision plan are eligible for reimbursement from your HRA.

REQUESTING REIMBURSEMENT FROM HEALTHEQUITY

If you do not or cannot use your HealthEquity debit card, you can request reimbursement of your eligible expenses through the HealthEquity Member Portal. After a claim has been settled, Anthem BCBS will file your out-of-pocket expenses under the GPI medical, dental and vision plans in which you are enrolled, if any, with HealthEquity. To request reimbursement, go to **www.myhealthequity.com,** review your expenses and select those for which you want to claim reimbursement from your HRA.

REIMBURSEMENTS

Claims are reimbursed daily — by check or direct deposit to your bank account — up to the balance in your HRA at the time the claim is processed. To add direct deposit, complete and return a *Direct Deposit Form* or add your banking information on **www.myhealthequity.com**. If you have questions or need help, call HealthEquity Member Services at **1-866-346-5800**.

If you do not have money in your HRA, or you do not have enough money in your HRA to cover the full claim (or the claim is not eligible for reimbursement from your HRA), the unpaid portion of the claim automatically will be considered for reimbursement from any available money in your health care spending account (if you are enrolled).

DECISION ON HRA CLAIMS

HealthEquity will review your claim and notify you of the decision within a reasonable time period, but not later than 30 days after receipt of your claim. This period may be extended for an additional 15 days if special circumstances apply and you are notified of the need for an extension within the first 30 days. The notice will explain the reason for the extension and the date by which HealthEquity expects to make a final decision on your claim. If the extension is necessary because more information is needed to decide the claim, you will be told what information is required and have 45 days from receipt of the notice within which to provide the specified information.

A benefit summary, called an "explanation of benefits" statement, will be sent to you when your claim has been processed. This will explain what expenses have been considered and how your payment was calculated.

If your claim is totally or partially denied or reduced, the notice will include:

- The specific reasons for the denial.
- The specific references to the plan provisions on which the denial is based.
- A description of any additional material or information required by the plan to reconsider the claim and an explanation of why such material or information is necessary.
- Information about whether a rule, guideline, protocol or other criterion was relied upon in reviewing your claim or a statement that such was relied upon and will be provided to you, free of charge, upon request.
- An explanation of how you can appeal the denial of the claim, including the time limits under which you can file an appeal.
- The availability of and contact information for any office of health insurance consumer assistance or ombudsman who may assist you with your appeals and review processes.
- A statement of your right to bring civil action under ERISA if you appeal and the claim denial is upheld.

Submitting a Prescription Drug Claim

You do not need to file a claim for benefits when you fill your prescription at a local CVS Caremark network pharmacy, the CVS Caremark Mail Service Pharmacy or the CVS Specialty Pharmacy. You pay your share of the cost when your prescription is filled. If you have money in your HRA and/or health care spending account, you can use your HealthEquity debit card at the time your prescription is filled.

If you forget your ID card when filling your prescription at a local CVS Caremark network pharmacy, let the pharmacy know that you have coverage through the CVS Caremark network. They may be able to verify your coverage if you provide them with your Social Security number.

See "Prior Authorization" for more information on how to obtain authorization for prescription medications requiring approval before they can be considered by the plan.

Appealing Denied Claims

You have the right to appeal any claim denial (in whole or in part). The plan has:

- **Two levels of internal appeals** (the second level of appeal is voluntary) — where claims are reviewed by the appropriate claims administrator, as noted below:
  - Anthem BCBS — for medical claims.
  - CVS Caremark — for prescription drug claims.
  - HealthEquity — for HRA claims.
  - The Graphic Packaging International Benefits Committee — for eligibility and enrollment (including dependent verification) denials and second level HRA claims.
- **One level of external appeal** — where claims are reviewed by an external, independent review organization.

  This external level of appeal does not apply to claim denials associated with eligibility, enrollment or the HRA.

If your coverage is terminated retroactively, you are entitled to a separate appeal. See "Appealing Retroactive Coverage Terminations" for more information.

INTERNAL APPEALS

You must complete at least the first level internal appeal process before requesting an independent, external review unless:

- The claims administrator fails to comply with the requirements for the internal appeal review, or
- You are requesting an expedited claim review, in which case you can request both an expedited internal appeal and an expedited independent, external review.

First Level of Internal Review

When a claim is denied (including prior authorization requests), you (or your authorized representative) may request, in writing, a formal review. **This request should be made no later than 180 days after you receive the claim denial.**

If your claim is for **urgent care requiring prior authorization**, you (or your representative) can request an expedited appeal by calling:

- **For medical claims**: Anthem BCBS Customer Service directly at **1-855-272-0696**.
- **For prescription drug claims**: CVS Caremark Customer Care at **1-800-774-5780**.

An expedited appeal for the denial of an urgent care claim does not need to be in writing.

Note: Certain urgent prior authorization requests may be eligible for expedited external review in lieu of this internal review. See "Expedited External Appeals" for more information.

"Urgent" means that a quick decision is needed because any delay could jeopardize your life or health, your ability to regain maximum function or, in the opinion of a doctor with knowledge of your medical condition, subject you to severe pain that cannot be managed without the care or treatment.

All other appeals should be submitted, in writing, to:

- **Eligibility and enrollment requests** (the form for submitting your appeal can be requested through the Your Benefits Resources Customer Service Center):

  Claims and Appeals Management
  Graphic Packaging International, LLC
  P.O. Box 7105
  Rantoul, IL 61866-7105
  1-800-201-6885

- **Dependent verification denial requests** (the form for submitting your appeal can be requested through the Dependent Verification Customer Service Center):

  Dependent Verification Center
  Attention: Appeals
  P.O. Box 1434
  Lincolnshire, IL 60069-1434
  1-800-201-6885
  Fax: 1-855-769-5781

- **Medical claims**, including prior authorization:

  Anthem Blue Cross Blue Shield
  P.O. Box 54159
  Los Angeles, CA 90054-0159

- **Prescription drug claims**, including prior authorization:

  CVS Caremark
  Appeals Department MC 109
  P.O. Box 52084
  Phoenix, AZ 85072-2084
  Fax: 1-866-443-1172

Your appeal should include the following:

- Patient's name, date of birth and relationship to the employee.
- Service provider's name.
- Claim number.
- The dates of service.
- An explanation of why you are appealing and your desired resolution.

- Additional information (such as written testimony, comments, documents, medical records and/or other information supporting your claim, such as doctor statements, previous correspondence, authorization notices, bills and research) to support your appeal.

Your claim will be reviewed, taking into account all information submitted by you (or your representative) relating to your claim, without regard as to whether such information was submitted or considered in the initial claim decision. The review will not defer to the initial benefit determination, nor will it be conducted by individuals who were involved in the initial review of your claim (or their subordinates). In deciding any appeals involving health care judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational or does not meet medical necessity criteria, the appropriate claims administrator will consult with a health care professional and/or vocational expert who has the appropriate training in the field of health care for your condition. This professional will not be the one who was consulted in making an earlier determination on your claim (or his or her subordinate).

As part of the review, the claims administrator will provide you, free of charge, with any new or additional evidence considered, relied upon or generated in connection with your claim. In addition, before your claim can be denied based on new or additional rationale, you must be provided, free of charge, with that rationale and have a reasonable opportunity to respond before the date the final claim decision is required.

Voluntary Second Level of Internal Review

If your claim continues to be denied following the first level of internal review, you (or your authorized representative) may submit a request for a voluntary second level internal appeal. This request should be made no later than 60 days after you receive the denial from the first level of internal review. Your request should be sent to the same address as the first level of internal review and include any additional information on which the claim can be reviewed.

Note: You are not required to complete a voluntary second level internal appeal before requesting an external appeal, where available.

Decision on Internal Appeals

If your claim is denied on internal appeal, the decision at each level of review will be provided to you in writing:

- With respect to urgent prior authorization requests, within 72 hours after receiving your appeal.
- With respect to non-urgent prior authorization requests, within 30 days after receiving your appeal.
- With respect to all other claims, within 60 days after receiving your appeal.

Each level of appeal will be reviewed in the same manner (except that the Graphic Packaging International Benefits Committee will review second level claims involving eligibility, enrollment or HRA denials).

The notice, which will be provided in written or electronic form, will include:

- Information to identify the claim involved, including the date(s) of service, the provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis and treatment codes and their corresponding meaning.
- The specific reason for the denial.
- The specific reference to the plan provisions on which the denial is based.
- A statement that you may receive, upon request and free of charge, reasonable access to any documents, records or other information:
  - Relied on in making the decision on your claim.
  - Submitted, considered or generated in the course of making the decision.
  - That demonstrates compliance with the administrative processes required in making the decision.
  - That constitutes a statement of the plan's policy or guidance applicable to the decision on your claim, without regard to whether the statement was relied on.

- Information about whether a rule, guideline, protocol or other criterion was relied upon in reviewing your claim or a statement that such was relied upon and will be provided to you, free of charge, upon request.
- For claims involving medical necessity or experimental treatment, an explanation of the scientific or clinical judgment used in reviewing your claim or a statement that this explanation will be provided to you, free of charge, upon request, along with the name of any health care expert who was consulting regarding your claim.
- An explanation of the voluntary internal appeal (for first level appeals) and external appeal review procedures.
- A statement regarding your right to bring a civil action under ERISA Section 502(a) following a denial.

Note: If your claim is still denied following review, or if no response is provided within the time periods identified above, you may have the right to file an external review. External review is not available for claims related solely to your failure to meet the plan's eligibility or enrollment requirements. In these cases, the decision on internal appeal is final and binding.

Additionally, you have the right to bring civil action against the plan under Section 502(a) of ERISA. (See "Your ERISA Rights" in your most recent *Benefits Supplement* for more information.) If you wish to bring a civil action against the plan, you must do so within the earlier of (1) one year after the date your claim is denied on internal appeal, or (2) two years after the date the service or treatment was rendered.

EXTERNAL APPEALS

If you initiated a first level internal appeal within the time periods required and your claim continues to be denied, you (or your authorized representative) may request an independent, external review. You have four months to file your request for an independent, external review after receipt of the final internal appeal denial. There is no charge to you to initiate an independent, external review.

Note: Only claims involving medical judgment (as determined by the external reviewer) and rescissions of coverage will be eligible for external review.

Your appeal should be submitted, in writing, to:

- **Medical claims**, including prior authorization:

  Anthem Blue Cross Blue Shield
  P.O. Box 54159
  Los Angeles, CA 90054-0159

- **Prescription drug claims**, including prior authorization:

  CVS Caremark
  Appeals Department MC 109
  P.O. Box 52084
  Phoenix, AZ 85072-2084
  Fax: 1-866-443-1172

- **Rescission of coverage** (the form for submitting your appeal can be requested through Your Benefits Resources Customer Service Center):

  Claims and Appeals Management
  Graphic Packaging International, LLC
  P.O. Box 7105
  Rantoul, IL 61866-7105
  1-800-201-6885

You do not have to resend any information that you submitted with your internal appeal. However, you are encouraged to submit any additional information that you think will be helpful to your claim. The claims administrator has five days following receipt of your claim to complete a preliminary review to determine whether your request is eligible for an independent, external review. You will be provided notification within one business day after completion of the preliminary review.

If your request is:

- **Incomplete**, the notice will describe the information or materials needed to make the request complete. You will have 48 hours to provide the missing information, or longer, if you are still within the original four-month filing period.
- **Complete but not eligible for an external review**, the notification will include the reasons it was not eligible and your right to contact the Department of Labor's Employee Benefits Security Administration.

- **Approved**, the claims administrator will assign the file to an independent review organization (IRO). Within five days of assigning the case, the claims administrator will forward your full file to the IRO. The IRO will send acknowledgement to you that it has been assigned to review your appeal and will offer you the opportunity to present additional information.

Expedited External Appeals

If you have received an initial denial notice or a final notice of denial following an internal appeal for an urgent prior authorization decision, you may be eligible to request an expedited independent, external review — without filing an internal appeal or while you are waiting on a decision on an expedited internal appeal.

You (or your authorized representative) may request an independent, external review if:

- Your initial claim denial is for a medical condition that meets the requirements for "urgent" (as defined in this section), or
- Your final internal claim appeal denial concerns admission, availability of care, continued stay or a health care item or service for which you received emergency services and you have not yet been discharged.

You (or your representative) can request an expedited independent, external review by calling:

- **For medical claims**: Anthem BCBS Customer Service at **1-855-272-0696**.
- **For prescription drug claims**: CVS Caremark Customer Care at **1-800-774-5780**.

An expedited external appeal review does not need to be in writing.

Decision on External Appeals

The independent review organization (IRO) will review any information and documents you provide on a timely basis without regard to any previous decisions or conclusions. If you submit new or additional information, the IRO will share the information with the claims administrator within one business day.

The IRO will notify you and the claims administrator, as applicable, of the final external review decision:

- In writing, within 45 days after the IRO receives the request for the independent, external review.
- Within 72 hours after the IRO receives the request for an expedited independent, external review. If the notice is provided verbally, a written decision will be provided within 48 hours.

If the decision is favorable and:

- It is a prior authorization appeal, the claims administrator will immediately provide the necessary authorization for the service.
- For any other appeal, the claims administrator will promptly process the claim for benefits.

Payment will be made according to the terms of the plan.

If the claim continues to be denied on review, no additional benefits are payable from the plan and you are responsible for charges incurred for any services received.

The decision resulting from the independent, external review is final and binding on all parties. However, if your claim is still denied after exhausting all your appeal options, you may have the right to bring civil action against the plan under Section 502(a) of ERISA. (See "Your ERISA Rights" in your most recent *Benefits Supplement* for more information.) If you wish to bring a civil action against the plan, you must do so within the earlier of (1) one year after the date your claim is denied on final appeal, or (2) two years after the date the service or treatment was rendered.

Appealing Retroactive Coverage Terminations

Your coverage may be terminated retroactively if you or your enrolled family member:

- Performs an act, practice or omission that constitutes fraud.
- Makes an intentional misrepresentation of material fact.
- Fails to pay any required contribution timely.

Retroactive termination under these circumstances (other than failure to timely pay any required contribution) is considered a "rescission of coverage."

If your coverage is retroactively terminated (other than due to failure to timely pay required contributions), the Company (or its representative) will provide you at least 30 calendar days advance written notice of termination. The notice will include the reason and date your coverage is being terminated. It will also provide information about how you can appeal the decision. For purposes of these rescission appeal procedures only, Graphic Packaging International, LLC shall be the named fiduciary and shall have discretionary authority to resolve factual issues and make final determinations. All decisions shall be final and binding.

Overpayments

At the plan's option, any overpayment made by this plan (for any reason) that was paid directly to you can be recovered by:

- Offsetting the amount of overpayment against future benefits until the overpayment is recovered.
- Requesting that you repay the plan in an amount equal to the overpayment.
- Deducting the amount of the overpayment from your paycheck or paychecks if you return to work, where permitted by law.
- Taking legal action.

If overpayment has been paid directly to a provider, the plan will request that the provider repay the plan in an amount equal to the overpayment.

As a participant in the plan, you agree that the appropriate claims administrator and/or the Company has the right to collect such overpayments.

Coordination of Benefits With Other Plans

If you (or a family member) are covered under this plan and another employer's plan (your spouse's, for example), the two plans will coordinate benefits like this:

- Your plan pays first for your health care services.
- Your spouse's plan pays first for his or her health care services.
- For health care services for your children, this plan uses the "birthday rule" to determine which plan pays first. According to the birthday rule, the plan of the parent born earlier in the year pays first. If your spouse's plan has not adopted the birthday rule, the father's plan determines who pays first.
- For divorced or separated parents, the birthday rule does not apply. In these situations, the plan of the parent who has legal custody pays first. If the parent with legal custody has remarried, that parent's plan pays first, the stepparent's plan pays second, and the parent without legal custody pays last. However, if a court order determines that the other parent has responsibility for the child's medical care, then that parent's plan pays first.
- If a person is covered as both an active employee (or the dependent of an active employee) and an inactive employee (for example, laid off, retired or under COBRA), then the plan that covers the person as an active employee pays first.
- If the other plan does not have a coordination of benefits provision, that plan pays first.
- If none of the rules above determine who pays first, then the plan that has covered the person the longest pays first.

If this plan is providing secondary coverage for your spouse or child, this plan will pay the difference between what the plan would normally pay and what the primary plan paid. Here are two examples of the benefits this plan would provide if it were paying secondary:

- If your spouse's plan covers 50% of the maximum allowed amount for a service that this plan covers at 80%, then this plan would pay 30% of covered expenses (assuming you have met your calendar year deductible but not your out-of-pocket limit), up to this plan's coverage level of 80%. You are responsible for paying the 20% that remains.
- If your spouse's plan covers 80% of the maximum allowed amount for a service that this plan also covers at 80%, and you have met your deductible but not your out-of-pocket limit, then this plan considers the claim satisfied and pays nothing. You are responsible for paying the 20%, plus any deductible, that remains under your spouse's plan.

COORDINATION WITH MEDICARE

Rules governing when to enroll in Medicare are complex. If you have questions, contact Medicare at **1-800-MEDICARE** (1-800-633-4227) or visit **www.medicare.gov**.

Active Employees

If you are an active employee (or the spouse or child of an active employee) and enrolled in a Company-sponsored medical plan:

- You can delay your enrollment in Medicare Part A, Part B and Part D without penalty. However, you must enroll as soon as your coverage under the Company plan ends, or you may be charged a penalty.
- You can choose to enroll in both plans. When this happens, the Company plan will pay benefits first and Medicare will pay benefits after the Company plan — as long as you are actively employed[1]. Medicare will be responsible for limiting the total benefits to 100% of all charges.

1 If you have Medicare due to end stage renal disease, the rules are different. See "End Stage Renal Disease" for more information.

End-Stage Renal Disease

If you (or an enrolled family member) are entitled to Medicare coverage because of end-stage renal disease, this plan will pay benefits first for the first 30 months that you are entitled to Medicare. Following 30 months, this plan will pay benefits after Medicare Part A and Part B — regardless of whether you are actually enrolled in Medicare[2].

2 Beneficiaries eligible for Medicare Part A and Part B are eligible for Part D, Medicare's Prescription Drug Benefits. Enrollment in Medicare Part D is voluntary. If you do not enroll in a Medicare Part D plan, your prescription drug benefits may be covered according to the rules of this plan — without any reduction for benefits you may have been entitled to receive under Medicare Part D plan.

COBRA

IMPORTANT! To avoid late enrollment penalties and a gap in coverage, it is important that you enroll in Medicare Part A (hospital insurance) and Part B (medical insurance) as soon as you become eligible, regardless of whether you have COBRA coverage. If Medicare is effective before your COBRA coverage begins, your COBRA coverage will not end due to your Medicare enrollment, however, your Medicare coverage will be the primary payer. If you enroll in Medicare after your COBRA coverage begins, your COBRA coverage may end.

Different rules apply to Medicare Part D (prescription drug plans).

For more information, contact the Social Security Administration at **1-800-772-1213** or visit your local Social Security Administration office.

If you are a COBRA participant in this plan who is also entitled to Medicare:

- Your COBRA coverage can continue as long as you were enrolled in Medicare at the time your COBRA coverage began. Medicare will be your primary payor and this plan will be secondary. This plan will not reimburse any services that Medicare would have covered — regardless of whether you are enrolled in Medicare.
- If you become entitled to Medicare after your COBRA coverage begins, your Company-sponsored COBRA medical plan will end.

Assignment of Benefits

Except as provided in the plan provisions governing qualified medical child support orders (see your most recent *Benefits Supplement*) and the plan's subrogation and reimbursement rights (see "Third Party Liability"), no benefit under this plan shall be subject to alienation, sale, transfer, assignment, pledge, or encumbrance or charge, voluntary or involuntary, by operation of law or otherwise, and any attempt at such transaction(s) shall be void.

You may not assign your rights, benefits, or any other interest under the plan to a health care provider or any other individual or entity. The claims administrator may, however, in its discretion, pay a health care provider directly for services rendered to you or your covered family member(s). The payment of benefits directly to a health care provider, if any, will be done as a convenience to you and your covered family member(s) and will not constitute an assignment of rights, benefits or any other interest under the plan or a waiver of this anti-assignment provision.

Third Party Liability

If you or a covered family member (a "participant") receives benefits under the plan as a result of an incident for which a third party is or may be liable, the responsible party may be legally obligated to pay for medical expenses related to that injury or illness. If the participant has a right to a recovery or has received a recovery from any source, the plan may recover benefits paid on behalf of the participant.

A "recovery" includes, but is not limited to, monies that the participant, the participant's family members or other representatives receive or become entitled to receive from any third party (including a person or party, any person's or party's liability insurance; uninsured/underinsured motorist proceeds; Workers' Compensation, occupational disease or other similar legislation; no-fault insurance and/or automobile medical payments coverage), whether by lawsuit, settlement or otherwise. Regardless of how the participant or the participant's representative characterizes the money received as a recovery, it shall be subject to these provisions.

Under the plan, the participant has obligations and the plan has certain subrogation and reimbursement rights.

YOUR OBLIGATIONS

IMPORTANT! Solely for purposes of this plan's subrogation and reimbursement rights, notification to the plan means notification to Anthem BCBS, who can be reached at **1-855-272-0696**. Notification by any other means, including notification to your Human Resources representative, will not be accepted.

As a participant in this plan, you (or your covered family member) are required to cooperate with the plan to protect and pursue its subrogation and reimbursement rights, including:

- Promptly notifying the plan of how, when and where the incident resulting in personal injury or illness occurred, all information regarding the parties involved and any other information requested by the plan.
- Cooperating with the plan in the investigation, settlement and protection of the plan's rights. In the event that you or your legal representative fails to do whatever is necessary to enable the plan to exercise its subrogation or reimbursement rights, the plan shall be entitled to deduct the amount the plan has paid from any future benefits under the plan.
- Avoiding any actions that would prejudice the plan's rights, including any actions taken by your legal representative.
- Providing the plan with copies of all police reports, notice or other papers received in connection with the accident or incident resulting in personal injury or illness.
- Promptly notifying the plan if you retain an attorney or if a lawsuit is filed on your behalf.
- Immediately notifying the plan if a trial is commenced, if a settlement occurs or if potentially dispositive motions are filed in a case.

THE PLAN'S SUBROGATION RIGHTS

The plan has the right to recover payments it makes on a participant's behalf from any party responsible for compensating you or your covered family member for the illness or injury. The following rules apply:

- The plan has first priority from any recovery for the full amount of benefits it has paid regardless of whether the participant is fully compensated and regardless of whether the payments received make the participant whole for his or her losses, illnesses and/or injuries.
- In the event the participant and his or her legal representative fail to do whatever is necessary to enable the plan to exercise its subrogation rights, the plan shall be entitled to deduct the amount the plan paid from any future benefits under the plan.
- To the extent that total assets from which a recovery is available are insufficient to satisfy in full the plan's subrogation claim and any claim held by the participant, the plan's subrogation claim shall be first satisfied before any part of a recovery is applied to the claim, the participant's attorney fees, other expenses or costs.
- The plan is not responsible for any attorney fees, attorney liens, other expenses or costs incurred by the participant. The "common fund" doctrine does not apply to any funds recovered by any attorney the participant hires, regardless of whether funds recovered are used to repay benefits paid by the plan.

THE PLAN'S REIMBURSEMENT RIGHTS

If the participant obtains a recovery and the plan has not been repaid for the benefits the plan has paid on the participant's behalf, the plan shall have a right to be repaid from the recovery. The following provisions apply:

- The participant must promptly reimburse the plan from any recovery in an amount equal to the benefits paid by the plan on the participant's behalf, regardless of whether the payments received make the participant whole for his or her losses, illness and/or other injuries.
- Notwithstanding any allocation of designation of the participant's recovery (e.g., pain and suffering) made in a settlement agreement or court order, the plan shall have a right of full recovery, in first priority, against any recovery. Further, the plan's rights will not be reduced due to the participant's negligence.
- The participant and his or her legal representative must hold in trust for the plan the proceeds of the gross recovery (i.e., the total amount of your recovery before attorney fees, other expenses or costs) to be paid to the plan immediately upon your receipt of the recovery. The participant and his or her legal representative acknowledge that the portion of the recovery to which the plan's equitable lien applies is a plan asset.
- Any recovery obtained must not be dissipated or disbursed until such time as the plan has been repaid in accordance with these provisions.
- The participant must reimburse the plan, in first priority and without any set-off or reduction for attorney fees, other expenses or costs. The "common fund" doctrine does not apply to any funds recovered by any attorney the participant hires, regardless of whether funds recovered are used to repay benefits paid by the plan.
- If the participant fails to repay the plan, the plan shall be entitled to deduct any of the unsatisfied portion of the amount of benefits paid by the plan or the amount of your recovery, whichever is less, from any future benefits under the plan if:
  - The amount the plan paid on the participant's behalf is not repaid or otherwise recovered by the plan.
  - The participant fails to cooperate.
- In the event the participant fails to disclose the amount of settlement to the plan, the plan shall be entitled to deduct the amount of the plan's lien from any future benefit under the plan.

- The plan shall also be entitled to recover any of the unsatisfied portion of the amount the plan has paid or the amount of the participant's recovery, whichever is less, directly from the providers to whom the plan has made payments on the participant's behalf. In such a circumstance, it may then be the participant's obligation to pay the provider the full billed amount and the plan will not have any obligation to pay the provider or reimburse the participant.
- The plan is entitled to reimbursement from any recovery, in first priority, even if the recovery does not fully satisfy the judgment, settlement or underlying claim for or make the participant whole for his or her losses, illnesses and/or injuries.

OTHER

The plan is entitled to recover its attorney fees and costs incurred in enforcing this provision.

If the injured participant is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent or other representative shall be subject to the provision. Likewise, if the participant's relatives, heirs and/or assignees make any recovery because of injuries sustained by a participant, that recovery shall be subject to this provision.

The plan shall be secondary in coverage to any medical payments provision, no-fault automobile insurance, personal injury protection policy or other coverage (e.g., homeowner's insurance, boat owner's insurance, personal liability insurance, etc.), regardless of any election made by the participant to the contrary. The plan shall also be secondary to any excess insurance policy, including, but not limited to, school and/or athletic policies.

The plan sponsor has the sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary.